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Working paper for the WHO International conference

TOWARDS UNITY FOR HEALTH

Challenges and opportunities for partnership in health development

Phuket, Thailand, 10–13 August 1995

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Executive summary

Steady and sustainable progress towards greater quality, equity, relevance and cost-effectiveness in health services, epitomized by the goal of health for all and the primary health care strategy, calls for efficient mobilization of a wide array of talents and resources in society. The quest to deliver services that adequately address the health needs of both individuals and communities in a manner consistent with these values demands a comprehensive approach in which essential components – people, professions, policies, procedures, information – are considered in an integrated manner.

Unity must be created and the worldwide trend towards fragmentation at the level of health service delivery, which fundamentally upsets any long-lasting institutional change, must be averted. Influential stakeholders and actors must be united by a shared vision of future health reform and a long-term commitment to building an integrated approach towards health.

Discrepancies are observed worldwide between the desire for coherent and socially accountable health systems, on the one hand, and the growth of a variety of independent and uncoordinated health care initiatives, on the other. How can such contradictions be addressed?

The project "Towards Unity for Health" (TUFH) intends to study and promote efforts worldwide to foster unity to provide services based on people's needs, particularly through a sustainable integration of medicine and public health – or in other words, of individual health and community health-related activities – and coordinated inputs from five main stakeholders: policy makers, health managers, health professionals, academic institutions and communities.

The political, organizational, scientific and socioeconomic conditions to facilitate the conversion from a fragmented to a more unified approach in health service delivery should constitute the core of an important research and development agenda.

It is hoped that this document will be of some help to various actors operating in the health service delivery arena by affording them a better grasp of the values at stake and making clear the complexity of creating a productive relationship among key elements that constitute a system, while remaining pragmatic and focused on people's health needs.

The document starts by discussing the challenges of adhering to the values of quality, equity, relevance and cost-effectiveness and maintaining a balance among them. It goes on to note the commonly observed situation in which steady progress towards the fulfilment of these values is impaired by a growing fragmentation in the health service delivery system. This is exemplified by the persistent divisions – or missing links – between individual and community health activities, economic and social aspects of health, curative and preventive services, generalists and specialists, the public sector and the private sector, and health service providers and users.

The TUFH project submits that a momentum towards unity in health could be created by privileging attention to innovative approaches for integrating medicine and public health, in the hope of creating a ripple effect to heal other divisions or schisms in the health system. Arguments to choose this alliance as a strategic entry point are presented.

Criteria and conditions to support a momentum towards unity for health are outlined in four categories:

- development of innovative patterns of services for integrating medicine and public health;
- consideration of implications for health professionals;
- engagement in essential and sustainable partnerships;
- guidance sought in the evidence of impact.

It is assumed that for services to facilitate the coordination or integration between medicine and public health, at least three essential features should be present: focus on a reference population and a defined geographical area in the context of a decentralized health service; reference to organizational models for supporting the coordination or integration; and use of a comprehensive health information management system.

The document then reflects on the implications of unified approaches in health service delivery for health professionals, both for their practice and education. Emerging opportunities and challenges will lead to the delineation of new roles and reallocation of responsibilities and tasks among the workforce. The document considers how the preparation of such a workforce should influence educational institutions and programmes. The concept of the social accountability of educational institutions is presented and discussed, not only as a measure to align these institutions to better serve people's needs, but also to encourage them to be partners in shaping the future health system. The applicability of this concept to other types of institutions in the health system is evoked.

Essential to create a movement towards unity in health service delivery, five principal partners or stakeholders have been identified: policy makers, health managers, health professionals, academic institutions and communities. The

roles each could play in encouraging or restraining this movement are described, as well as their complementary strengths. The process of building and sustaining a fruitful partnership is discussed, and examples of collaborative processes among some partners are presented.

Finally, the document stresses the necessity for promoters of the TUFH approach and each partner involved to be critical of their specific and collective contribution towards improving quality, equity, relevance and cost-effectiveness in health services and to be amenable to adjustments of their behaviours and collaborative arrangements to that end.

Looking for better

Good health has been valued since the beginning of time. All cultures and nations throughout the ages have devised a wide range of actions to preserve or restore health.

The endless struggle to push the limits of life mirrors the ambition of mankind *vis-à-vis* the legendary immortality of gods. The ideal is to live a long and healthy life. Today, with the growing understanding and knowledge of risks and opportunities for health, expectations for good health throughout the lifespan are higher than ever.

Health is defined by the World Health Organization (WHO) as more than the absence of disease or infirmity, but as a state of complete physical, mental and social well-being. Accepting this definition makes the goal of good health even more ambitious, even utopian, as it implies reaching a state of permanent happiness. To add to the challenge, WHO has urged that everyone on the planet be afforded the opportunity to enjoy good health, a strategy known as "Health for All," endorsed by the community of nations.[1]

Translating these revolutionary directives sustainably into practical terms requires that most health systems undergo major reorientation. Two decades after the Declaration of Alma-Ata, it is fair to say that this reorientation has not taken place to the extent required. Indeed, disquieting evidence exists everywhere of increasing inequities and new pockets of poverty and ill health.[2]

"Putting all the pieces together" is a candid expression often heard from those who share the concern for improving the overall coherence and performance of health systems and making a positive difference to people's health status. That good health and ill health are the result of a host of biological, cultural, social and environmental determinants is well documented. So is the fact that efficient and sustainable interventions to prevent or cure disease, restore or promote health of individuals and populations are multifaceted.

As the inventory of positive and negative factors to shape health and health services unfolds, the necessity for a system approach prevails – an approach in which the main factors are identified and related to each other in a web of causations and interventions.

"There is no health system here" is another common expression from people disappointed by the absence of coordination between different partners' inputs in health, or the overlapping and undue competition between these inputs, or the difficulty in translating well-meaning policy statements into operational terms. Despite the knowledge that major health issues can be managed effectively and sustainably only through well-coordinated action, there is relatively limited evidence of the application of a systems approach. Innovative approaches are yet to be developed for an optimal mobilization and coordination of resources and talents to ensure a major success in disease control, risk reduction and health promotion, taking into account the political, organizational and financial feasibility.

The combination of some events such as consumers' growing expectations and awareness of comparative advantages of health interventions, limited resources to pay for health services, health professionals' aspirations for more gratifying patterns of work and the pressure on health policy makers to develop a more appropriate service delivery calls for a fresh look at how health systems are set up and managed and at how their constituent parts can best be coordinated.

At the outset, it appears essential to recall that a health system's purpose is to respond to people's health needs. As such, it must be based on clearly identified values to serve this purpose, namely quality, equity, relevance and cost-effectiveness. Adhering to any one of these values is not easy; adhering to all is a real challenge. In setting up or reorienting a health system, the implications of these values for different stakeholders must be well understood.

QUALITY

Even when we consider the phenomenon of health in its widest sense, we must pay privileged attention to the health status of individuals. The improvement of health of every person is the *raison d'être* of a health system. It should be and remain its basis and constant reference. A system that is not built on a people-centred approach runs the risk of being distracted from accomplishing its mandate by partisan and secondary tasks.

To ensure this people orientation, and although the concept of quality applies to any health actions, quality in individual health care should be given priority. In this context, quality can simply be defined as the measure by which satisfactory responses are provided to meet people's health concerns. It can be viewed from the angle of the beneficiaries and service providers.

Although references for quality vary with the level of socioeconomic development and the availability of technologies and skilled staff and technologies in a given context, beneficiaries of health care invariably expect their concerns to be addressed with humanity, respect and personal attention through a comprehensive array of services for the fulfilment of their legitimate aspiration to well-being. In any context, people's expectations will evolve with their capacity to understand the determinants of health and ill health and their informed judgement of what may suit them best in particular circumstances.

The concept of quality is also shaped by service providers in setting standards and norms for good practice that will also evolve with the advent of more sensitive evaluation measurements and procedures and new health technologies. Policies for quality improvement have developed worldwide, due to the activism of both health service beneficiaries and providers. Evidence-based data on quality will also bring the transparency to allow empowerment of beneficiaries and sound competition among providers.

EQUITY

Getting the best in health service cannot be the privilege of a few, but the right of everyone. In the code of health ethics, the value of equity should echo the value of quality. Excellence in health service should be advocated with the intention of extending it to all. By endorsing the "Health for All" goal, WHO and its Member States have amply highlighted this value. Therefore the trend for increased action towards improved equity in health care and health status is most reassuring.[3] But good intentions for making health benefits available to everyone have yet to be implemented satisfactorily; there are obvious disparities among nations as well as within each nation.

The goal is to reduce any form of discrimination based on race, sex, religion, culture or socioeconomic status and to install mechanisms by which everyone in a given community can be guaranteed access to a minimum set of appropriate services to ensure an enjoyable and productive life. This right should be accompanied by another right – also considered a duty – for all to be empowered to protect and promote their own health by being adequately informed about health risks and opportunities and healthy lifestyles.

The mounting sensitivity for equity issues in health goes beyond an ad hoc attention to the poor and uneducated, but embraces society at large, since marginalization from the mainstream of health services can affect such subgroups as the homeless, the jobless and those who are alone. These are groups in which any of us could find ourselves. And since the circumstances of life can change abruptly and bring anyone to the brink of despair, society should be vigilant and prepared to mobilize solidarity to help all those who are at risk of losing their social rights, including the right to health.

For health entrepreneurs, the simultaneous quest for quality and equity is like a "dream" – a star in the sky, not easily or immediately reachable, but very attractive and inspirational as a target. For critics, providing the best possible service to everyone in society without exception is utopian, as quality and equity are seen as being supported forces working in opposite directions (Fig. 1).

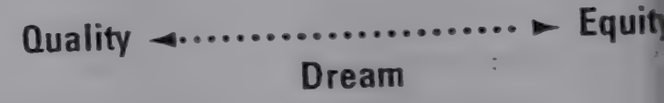

Figure 1. Dream axis

Such critics argue that to a certain extent the energy and resources invested to improve quality are detrimental to the cause of equity. However, situations exist where the development of high-quality products or procedures – such as the production of effective vaccines or the introduction of educational or preventive programmes – affects the health of the masses. Obviously, in such situations, sophisticated research and development efforts were designed to benefit the multitudes.Aspiring simultaneously to both quality and equity may seem problematic because quality is seen as referring to a commitment to spare no effort or cost to restore or protect the health of individuals. On one hand, with ris

costs in health care and limited national health budgets, the "*impossible dream*" theory to accommodate both quality and equity gains strength with the increasing evidence that if more sophisticated assistance is given to some, other and larger groups will be denied basic health services.

On the other hand, proponents of the "*possible dream*" theory argue that a point of equilibrium can be reached on the "dream axis" between the forces supporting attention to individuals and those supporting attention to the masses, if certain conditions are fulfilled. This is the quest for relevance and cost-effectiveness. While the "dream axis" represents the aspiration towards fulfilment of all expectations for all, the "reality axis" reminds us of the necessary use of rules and negotiations for the realization of our dream (Fig. 2).

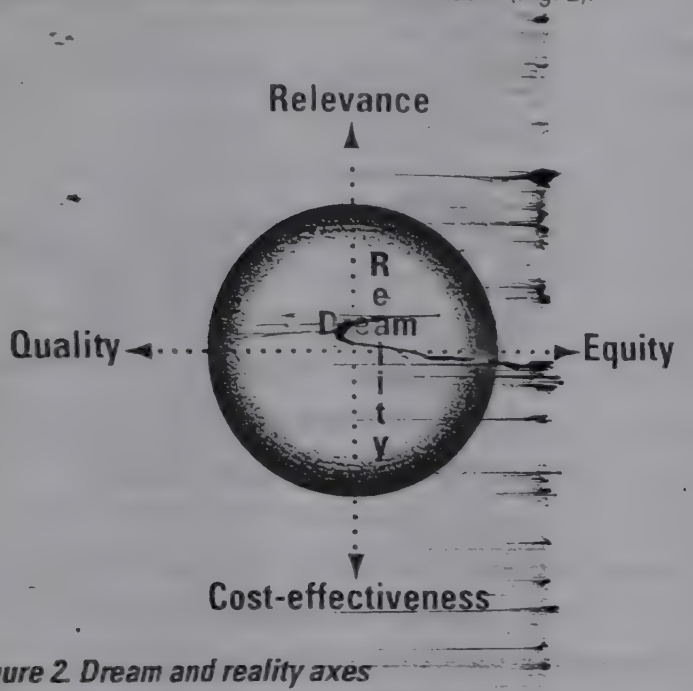

Figure 2. Dream and reality axes

RELEVANCE

Relevance is the measure by which priorities have been set in an action programme, accepting that the most important problems must be tackled first. Criteria for relevance will necessarily vary with the epidemiology and the vulnerability of people and the appreciation of priorities by different subgroups in a given context. The idea is that by applying the principle of relevance, both quality and equity can be catered for if resources are preferentially used to address the most important health concerns or to direct efforts to people and groups in greatest need.

The logic of "rationalization" may always be mistaken for that of "rationing." Indeed, controversies will inevitably arise as priority-setting is equated with reduction of health services by those who are either denied certain categories of services that health authorities consider less important or who have conditions imposed on them if they persist in their wish to obtain the desired services. Efforts to justify the priority-setting on quantifiable grounds will not level the different qualitative appreciations of priorities, and negotiation will always be needed in order to reach a consensus or an acceptable compromise.

Examples of difficulties in priority-setting are numerous. For instance, in an industrialized country it may be necessary to choose between support for programmes of prevention and assistance in adolescent pregnancies and the extension of intensive-care facilities for the elderly with no restriction on age or health condition. In a developing country experiencing an epidemiological transition, the control of gastroenteritis, a major killer in early childhood, may compete with the installation of basic geriatric services in a population rapidly becoming older. The difficulty arises because different health problems are considered equally important by different fractions of the society.

While the rationale of priority-setting may be consistent with a national health system aiming at universal coverage with taxpayers' funds, it may be less appropriate where there is a health insurance scheme, a managed-care organization or fee-for-service arrangements.

COST-EFFECTIVENESS

The value of cost-effectiveness is amply recognized at times of budget restriction, as with any innovative measure to make the best use of available resources in delivering a given service.

Comparative advantages of certain procedures will be highlighted, leading to constant updating of practice guidelines. Some procedures may be declared obsolete or less cost-effective than others. New procedures will be introduced. Healthier lifestyles and preventive measures may be emphasized for being more cost-effective investments. The growing desire for more transparency and evidence-based practices will have implications in health service development and working opportunities and call for important readjustments in the health professions.

With the evidence that certain procedures can be carried out at an equal standard of quality by less-educated and less costly health staff, critical reviews are being encouraged for an optimal allocation or reallocation of tasks and responsibilities among the health professions. Consequently, shifts of responsibilities can be envisaged between generalists and specialists, doctors and nurses, nurses and allied health personnel and social workers. In many cases, self-care and care provided by family members will be advocated. Collaboration among the health professions is increasingly being influenced by principles of negotiated transfer of responsibilities, substitution, complementarity or competition.[4]

IMPASSE AND COMPASS

Understanding and promoting the values of quality, equity, relevance and cost-effectiveness gives rise to specific streams of research and development. Steady progress towards adherence to these values calls for clearly defining them and specifying norms, indicators and criteria. This by itself is a challenge, particularly as the definition of these values continues to evolve and requires unanimity of views of the main stakeholders. However, a bigger challenge for a health system is to strike a satisfactory balance in trying to adhere to the four values.

The crossing of the dream and reality "axes" may stand as a "health compass." The metaphor of the compass is chosen to illustrate the complexity of health system changes aiming at optimal adherence to the four values and the tension this implies. Obviously, the image of the "compass" as an instrument to follow in one direction does not fit the task of determining directions in health care, as we cannot privilege one value at the expense of the others. All four values must be given adequate emphasis. One of the main tasks of future health systems will be to manage the tension generated by this challenge.

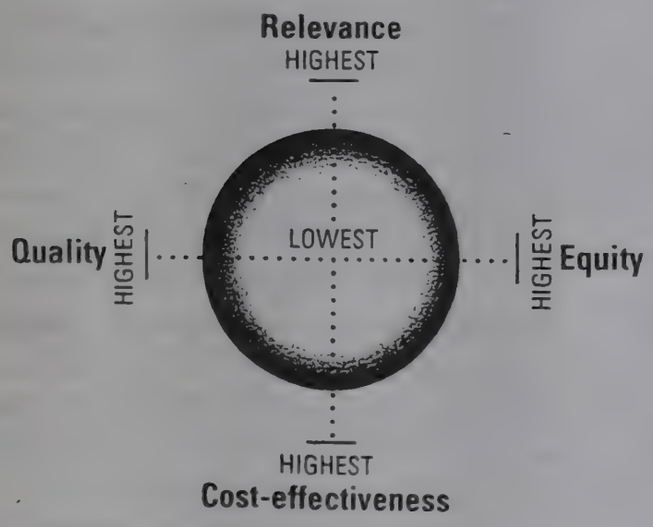

Figure 3. The health compass

Understanding the interrelationship between these values should allow health planners and organizers to conceptualize how to direct (or redirect) programmes of action. To illustrate this point, Fig. 3 depicts the four values plotted on a diagram. The crossing of the axes is the lowest point and the extremities of the axes are the optimal points on the scale of values. This figure represents an ideal health care system that is balanced in attempting to meet the needs of individuals and populations. Note that the circle does not extend to the periphery of the figure: in all countries there are limits to the extent to which services can be provided.

Variations around this template illustrate different degrees of adherence to the four values in health care systems worldwide. Figure 4 shows how some may favo one or more values above others.[5]

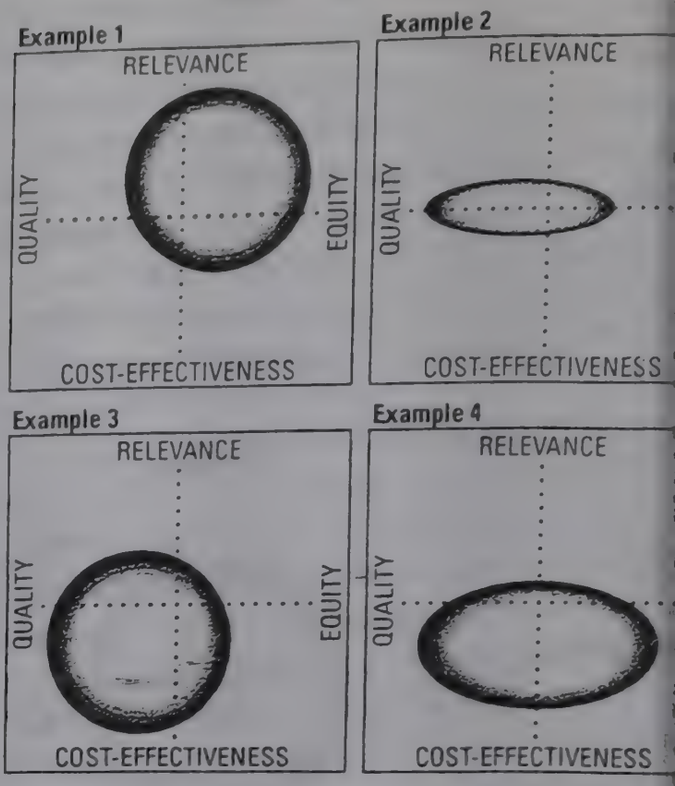

Figure 4. Degrees of adherence to values

Example 1: The health care system has worked well to achieve a system that provides services to all, even addres ing the health care priority ~~areas,~~ but the quality and cost-effectiveness of the services are poor. Such a system may exist where there is a national health service with minimal input from the consumers and no competition to stimulate cost-effectiveness and quality.

Example 2: The health care system is consumer driven, demanding quality – at high cost – but neglecting to meet priority health care needs and the need for equity. Such a system exists in many industrialized countries where there no impetus (such as from government or private-sector planners and organizers) to plan for or meet the needs of society, including those of the underserved.

Example 3: The health care system is characterized by a consumer-driven system in which costs are constrained by competition or regulation. As in example 2, the system, whic is emerging in many industrialized countries, looks after the interests of its "customers" only, resulting in minimal attentio to health care priorities and underserved populations.

Example 4: The health care system makes good use of its resources while providing high-quality care for most of its citizens, but has not planned effectively to meet priority heal

care needs. This example is seen in many countries where the health sector fails to take a comprehensive approach aimed at optimal coordination of numerous inputs to protect and improve health.

The above examples characterize various patterns of health care systems that are less than optimal and for which some reform would be justified. Through understanding the implications of these values and the way they relate to each other in the context of an evolving health system, principal partners may grasp the scope of the challenges they face in living up to their commitments.

Technically appropriate and socially acceptable compromises must be sought, which requires a shared vision and efficient collaboration from the principal partners. Failing these, a balanced approach towards the values outlined in the "health compass" would vanish, as there is a natural tendency for each stakeholder to privilege one value at the expense of others. Politicians, in need of voters' support, for instance, may be tempted to exploit preferentially the "equity" direction; social activists may wish to be the advocates of what people need most and take essentially the "relevance" route; health care providers may choose to be exclusively on the side of patients by advocating unlimited access to costly technologies under the cover of the "quality" direction; economists may favour the "cost-effectiveness" direction at the expense of social and humanitarian aspects.

At certain stages of their development, national health systems have been under the prevailing influence of one or the other forces, with the consequence of successive changes of emphasis in health care delivery and limited progress towards health status improvement.

Partners as different as health policy makers, health managers, health care providers, academics and consumers increasingly realize they cannot continue to neglect negotiation and compromise in order to protect their turf and maintain their sectoral privileges and prerogatives, and that such practices are even less appropriate as a foundation for sound health system development. Also, to be successful, efforts to improve the overall performance of the health system in meeting people's needs must rest on commitment to a common agenda for action from a variety of talents and resources.

These efforts must go beyond measures of cost-containment or financial management – sometimes abusively equated with "health reform" – to enable the system to keep up with its usual commitment to services delivery, but also to encompass the comprehensive mandate to ensure optimal adherence to the values of quality, equity, relevance and cost-effectiveness.[18,20,21,22,23,29] The task set by this agenda is too big and complex to be left predominantly to one school of thought or in the hands of any one group. Unnecessary rivalry and unconcerted action among the main actors on the health chessboard lead to an impasse. There seems to be no alternative to unity in action.

How can a movement towards unity be initiated, encouraged and desired by all those concerned?

▼

The benefit of collaborative action can be illustrated by the search for optimal use of human resources in the health field, which in principle should result from a series of interventions such as: clearly defining a mandate and operational model of health settings where future health personnel will function; properly defining roles and scopes of responsibilities of health personnel; adherence to guidelines for good practice; attention to appropriate working conditions and motivation at work; and action to ensure an efficient educational system.

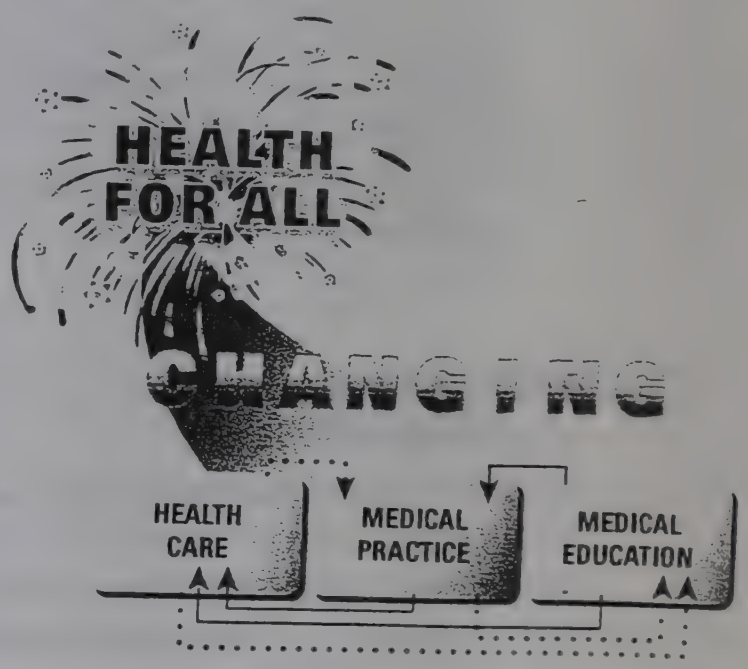

Figure 5. Coordinating changes

Each action is influenced by others. It is therefore opportune to understand the interrelationship between organizations or institutions that carry the major responsibility in human resources development and to encourage productive interaction. Figure 5 points out the desirable network of relationships between changes in health care, medical practice and medical education to make steady progress towards a commonly agreed-upon goal, in this case, the WHO goal of "Health for All."[13,26,7]

Although the change process can be initiated at

different entry points, there is a prevailing thought that through the strength of educational programmes alone, changes in behaviour will occur and endure. In contrast, in spite of goodwill, changes introduced in education will not necessarily induce sustainable changes in practice, which in turn will not influence health care and health status unaided. In reality, more important determinants than education – and over which educational planners have no control – are at work on practice.[8] *For instance, the improvement of remuneration and job opportunities is likely to have more influence in attracting doctors to family practice than the most exciting educational exposure to this discipline.*

Specific dynamics are at work in health care organization, professional practice and academic institutions, and different sets of factors influence them. The ideal situation is one of synergy, created by coordinated changes in the three components. In the case of promotion of family medicine, for instance, we might envision the development of a government policy to recognize family medicine as a foundation for health care organization, along with provision of professional and material incentives to practice as family physicians and development by academic institutions of research and education, in order to promote family medicine as a respected discipline.[9]

CREATING CONVERGENCE IN A FRAGMENTED MILIEU

Figure 6 captures the mood in two situations, wherein the snake symbolizes the health service delivery system. The ideal situation (A) is one in which principal stakeholders share a vision and commitment to unity in health action, whereas the more common current situation (B) is one in which stakeholders are more concerned with protecting their areas of interest, at the risk of fragmenting the system and preventing it from functioning properly. Shifting from the "angry snake" scenario (B) to the "happy snake" scenario (A) is a major challenge.

How can such harmony be developed? What organizational innovations are needed to make this shift possible? What are the opportunities, rewards, challenges and constraints that go with them? Let us first consider the level of fragmentation and what causes it.

Fragmentation in health service delivery is not just a static reality, it is a galloping phenomenon that threatens to level out important health gains and combat major effort towards health system change. Significant divisions exis sometimes widen between individual health care and community health services, economic and social aspects health, biomedical and psychosocial models, curative an preventive care, services provided by generalists and by specialists, public and private sectors, health care provid and consumers.

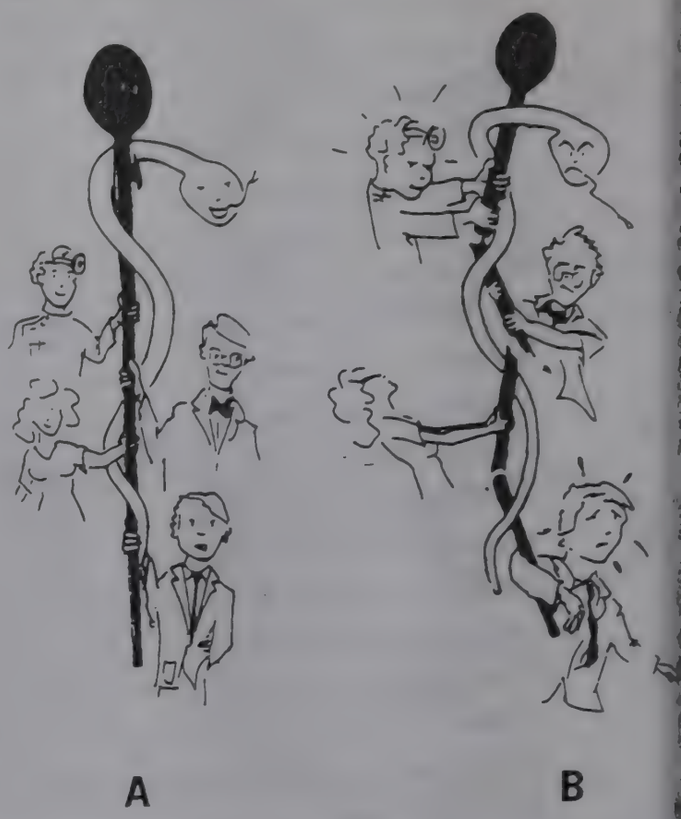

Figure 6. Happy and angry snakes

With the wave of cost-containment measures and th rapid introduction of managed-care schemes and compe tion within the health sector, there is a risk of further frag mentation, turf protection, duplication of work and waste resources at the expense of quality, equity and optimal overall management of the health system.

This is a universally relevant observation because of similar factors at work worldwide: the propensity for an analytical approach to problem-solving based on the extensive use of science and technology at the expense holistic approach based on epidemiological and social sciences; paradigms biased towards action against disea instead of action for health; service and care too often tailored to the convenience of the health professions than people's actual needs and expectations; an unexamined division of labour among health care providers and betwe health care providers and consumers; traditions and belie and above all, the inherent complexity of encompassing th wide spectrum of health and ill-health determinants in appropriate and coherent packages.

The universal call for "Health for All" was and still is a formidable social goal with the potential of triggering important health system changes. But 20 years after its release to the world, we still perceive a wide need for innovative health reform proposals powerful enough to attract and engage policy makers, health managers, health professionals, academia and consumers alike in a collaborative pattern of work for the steady and sustainable improvement of quality, equity, relevance and cost-effectiveness in the health sector.[10,15,24,25,26,27]

It has been implicitly assumed that the strength of the call would eventually call forth the convergence of talents and resources needed to fulfil such an ambition. However, relatively limited methodological work has been done to facilitate and accelerate this convergence on a sustainable basis. Synergies mainly have not occurred, and divergence among stakeholders in the health care delivery system is more prevalent than convergence. A fundamental effort must be made to set in motion strategies that can eventually create a unity of purpose and action among the principal stakeholders or partners in health. Such an effort, while striving for acceptable compromises among centrifugal forces and giving due consideration to opportunities and constraints from all sides, could deserve to be called "health reform."[11,12,13]

It is assumed that a dynamic process towards convergence should be enhanced by focusing on reducing the schism between medicine and public health or, in other words, on optimal collaboration between actions geared towards individual health and community health care at primary level.*

*This document reflects the view that medicine should not be synonymous with individual health care and public health with community health care. The term "medicine" is not intended to designate activities conducted solely by physicians, and the term "public health" is not intended just to designate activities other than those conducted by the private sector. The expression "integrating medicine and public health" will be used interchangeably with "integrating individual and community health care" in this document.

Although these two areas do not always operate in strict isolation from each other, it is fair to say that too often individual and community health services are conducted in relative ignorance of each other, compete for similar resources and lead to separate institutions and careers, using competing paradigms of work.[14,15]

We support the notion that if optimal organizational patterns of health services are developed in which inputs from the medical and public health fields are jointly planned and managed with the aim of serving the cause of people's well-being in their living environment, a major fracture in the health system would be healed, which would open the path for further progress towards a more unified approach in health services and in the health sector as a whole.[15,16,17,28]

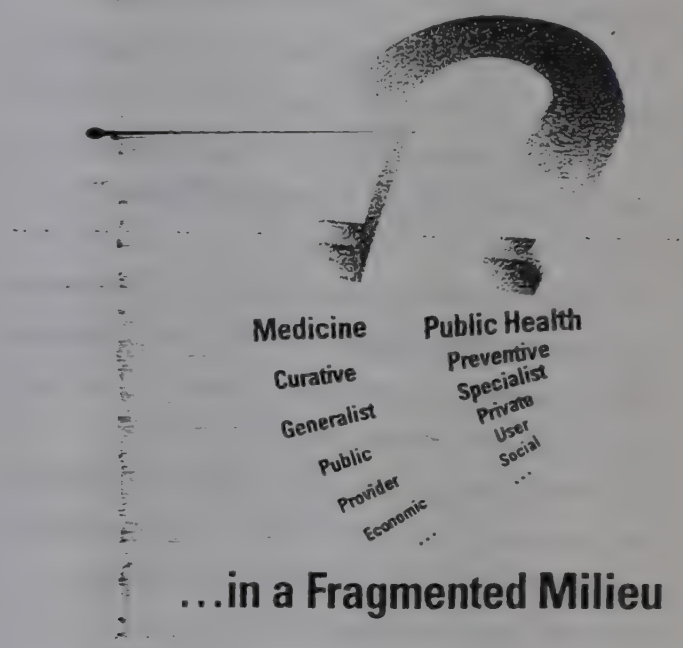

Figure 7. Entry point to heal divisions

What arguments can be put forward to support the assumption that the integration of medicine and public health is a critical entry point to initiate a process of unity? Is a coordination or integration of attention given to one individual and to more than one individual (family, local community or entire district) at the core of sustainable, responsible and problem-solving health service? Some of the arguments may be as follows:

- There is a strong correlation between personal health and the lifestyles collectively adopted in a given society.
- Health and everyone's quality of life increasingly depend on environmental factors. In return, individuals may be major causes of environmental protection or deterioration.
- Balanced attention to disease prevention, risk reduction, health promotion and curative services is necessary for comprehensive and efficient action in health.

- Biomedical and epidemiological sciences are mutually supportive and investigate complementary facets of health and development.
- A population-wide health programme is more likely to take place when collaborative ventures are enhanced between the private and the public sector.
- Peace and development in any society are best served when a balance is struck between individual freedom and social solidarity with those most in need.
- Complementarity and mutually rewarding interaction can be developed between community-oriented health services at primary care level and disease-centred services at secondary and tertiary levels.
- Convergence of individual and community health activities can trigger opportunities for an intersectoral approach and productive teamwork needed in health system changes.
- A blend of individual health and community health activities provides a solid base from which to review the scope of responsibilities among the health professions, and opens a spectrum of new job opportunities.
- The mismatch will be reduced between innovative community-oriented health professions educational programmes and conservative biomedical patterns in health services delivery, and vice-versa.
- We should anticipate mutual respect and a better understanding in the delineation of responsibilities between beneficiaries and health care providers regarding health promotion and disease control.
- Finally, and most important, a health service aiming at integrating individual and community health provides a valid platform for conflict resolution in trying to harmoniously achieve quality, equity, relevance and cost-effectiveness in health.

It is probably fair to say that no individual health situation is without some effect on the population's health and no population health measure is without some effect on everyone's health.

As the division between medicine and public health is largely man-made and artificially maintained, the schism will need to be healed by mankind's will.

We may reasonably expect that if fragmentation results from pursuit by different interest groups and stakeholders of agendas to protect privileges and attain self-determined objectives, unity in action can be gained if these agendas are molded by a shared vision and commitment. In a world where the value of competition is enhanced and the reductionist approach prevails over the comprehensive approach, we should not expect unity to come about naturally. Unity must be desired, planned and created.

TOWARDS UNITY FOR HEALTH

The term "Towards Unity for Health" stands for a dynamic process for the development of strategies and conditions for unity in purpose and action by key partners/stakeholders in the health sector, in order to establish a sustainable, people-based health service in line with the values of quality, equity, relevance and cost-effectiveness.

A "TUFH project" is a field project conceived to adapt and apply the principles of the TUFH approach and to improve it through research and development. For a TUFH project to succeed in unifying fragmented health service delivery, basic cultural and technical requirements must be met.

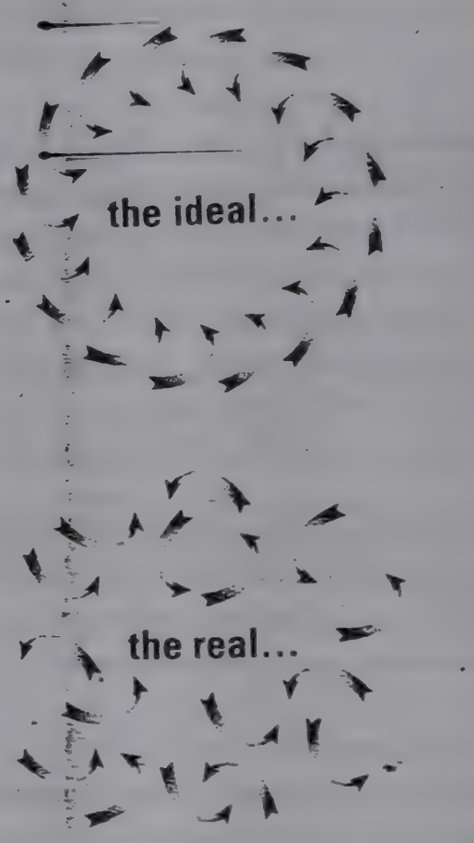

Figure 8. Moving from the real to the ideal

Cultural requirements

Principal partners or stakeholders, having realized that fragmentation ultimately leads to an unproductive health service, a loss of quality and a rise in inequities and costs, as well as threatening to limit their expansion and compromise their own interests, should welcome the perspective of deep health system changes and the opportunity to redefine their roles and spectrum of responsibilities within a new paradigm of integrated action. We should expect that such a mindset would be acquired after long and open debates and fair consideration of opportunities and constraints.

Technical requirements

The TUFH approach is not an ideology, nor is it a standardized methodology. It is, however, a framework that expresses the shared will of multiple partners to shape a sustainable health service based on people's needs. It is founded on the assumption that a coordinated or integrated approach is [illegible] to improve quality, equity, relevance and cost-effectiveness in health. Data must be collected from observations and experimental work to either support or refute this assumption.

As no unique recipe exists in health service organization, [illegible] suggested by the TUFH approach needs [illegible] different socioeconomic contexts. However, it [illegible] criteria will be recognized as being of global relevance. It is hypothesized that a momentum towards "unity" can be created, sustained and expanded in a TUFH project if a number of criteria grouped under the four following categories can be adhered to:

- *use of innovative patterns of services for integrating medicine and public health;*
- *consideration of implications for health professionals,*
- [illegible]
- *search for and evidence*

These criteria are further described [illegible]

[illegible] preventive,

[illegible] tion for health development is [illegible]

[illegible] s unitary and

[illegible] The building of an integrated [illegible] any important building [illegible] part of a comprehensive strategy for [illegible] will be a time- and energy-consuming process. [illegible] approach may also be used to demonstrate [illegible] of the general population [illegible] features (e.g. age, socioeconomic [illegible] violence, ethnic strife, unemployment, [illegible] smoking, occupational hazards), [illegible] malaria, diabetes); or a combination of these (e.g. adolescent pregnancy, drug addiction in school [illegible], poor morbidity of the unemployed).

A TUFH project is intended to ensure that any individual within the reference population, either in the context of a general population programme or a more targeted one, as described above, is given due attention. Therefore, measures must be taken to avoid selecting users based on socioeconomic factors or other discriminatory factors. Further, a reference population should not be limited to a population of self-selected patients and their families. The principle of a reference population implies that there is a continuously updated knowledge of the population under study, from the point of view of demography, vital events and health status.[33]

The issue of accountability can be viewed from an

[illegible] BIBLIOGRAPHY

[illegible] can best be developed when [illegible] are clearly defined, in terms of both [illegible] boundaries.

The [illegible] is closely associated with an [illegible] provides a basis to ensure that [illegible] cultural or economic status, will be [illegible] able to benefit from any priority health [illegible] allows the use of epidemiology as a science [illegible] managing health services.

In defining a reference population, issues of size and [illegible] must be addressed. Is there an ideal population size that a health service should consider? Although there is no strict, quantitative rule applicable to all contexts, a qualitative recommendation has been made by WHO, which considers the "district" to be the ideal setting. A district is described as a clearly defined administrative area where some form of local government or administration takes over many of the responsibilities from central government sectors

epidemiological angle. In considering the prevalence of a disease or health problem in the general population, we would be inclined to consider the numerator of the fraction (e.g. diseases that have occurred) a target for individual health care providers, whereas the denominator of the fraction (the general population) would be a target for public health managers. This division of labour, although currently seen, is challenged by the TUFH approach, and health professionals concerned with a more systems approach will consider this division somewhat artificial and counter-productive for people's health.[15] Clinical epidemiology and public health medicine are examples of disciplines cutting across the traditional boundaries between individual health and community health.[32]

By understanding population dynamics and by trying to embrace all main health concerns of a total population, we will be more inclined to consider the natural history of life, health and disease and major influences on their course, and enlarge our scope of interest and responsibilities for a more comprehensive approach to health and development.[33] The feasibility of applying this principle in the context of private practice and health insurance schemes is of concern.

The geography

Consideration of time and space parameters in health development is essential for a holistic approach. Understanding the major physical, biological, social, cultural and economic health determinants at work in a given environment is the foundation of a sound and comprehensive people-oriented health system.[34] The ideal configuration would be one with a well-defined territory of manageable size, where health needs are regularly assessed, health services planned and organized accordingly and progress in health care and health status monitored.[35,36] This territory could be a village, a town, a district or a province, depending on the local context.

Also ideal would be the existence of a political and administrative jurisdiction providing leadership and support for an optimal mobilization, distribution and use of available resources in that territory. An overview of all major health events and interventions concerning people living in a well-defined area facilitates coordination of multiple stakeholders' inputs and contributes to creating a mindset, if not an ethos, for accountability for people's health conditions. In targeting a territory, we gain an opportunity to understand the rich relationship of elements that cause well-being, health, disease or suffering and to identify the multiple partnerships required to move steadily towards improved quality, equity, relevance and cost-effectiveness in health.

It is probably fair to expect that dichotomies and wasteful overlap may fade away with institutionalized mechanisms to reward population and territory-wide intervention programmes. The concept of a health district has been promoted to that effect. A district has been described as an ideal geographical area at the level of which health services could be usefully decentralized for planning and organization and health status monitored, with the understanding that it should be large enough to justify its own health surveillance system but small enough to allow an efficient coordination and management of health interventions.[37]

The principle of territorial responsibility is best served when different stakeholders are bound by the same commitment to public service, usually enhanced by the mandate of a public institution or kept vivid by individuals or groups distinguished by a sense of social responsiveness. For instance, the notions of catchment area and responsibility for coverage are working principles of district health centres or community hospitals staffed by civil servants and supported by public funds. Coalitions of voluntary aid and public projects are more likely to be successful when there is a focus on defined targets within given geographical confines.[38]

In the context of the WHO "Healthy Cities" programme, a multidimensional response is proposed to address priority health and social concerns in metropolitan areas. Factors as diverse as housing, sanitation, transportation and employment that bear on health and well-being are being analysed and acted upon in a coordinated way through the mobilization of public and private networks of agencies and institutions devoted to a cause recognized as important within a given zone.[39] At a national scale, policies for a population and territory-based health service system can yield interesting results. The Cuban experience, for instance, has demonstrated how community-based allocation of primary health care resources can contribute to the achievement of impressive health outcomes.[40]

We may wonder how a population and territorial approach can be promoted and adopted in the wake of growing fragmentation in the health service delivery system and prominence of stakeholders' specific agendas over coordinated action. How can it be made attractive to a workforce essentially driven by private entrepreneurship, competition, consumerism and fee-for-service? Of course, anecdotal situations exist in which people act for

the public good. For instance, a group of private general practitioners in Belgium initiated a circumscription-wide surveillance programme of intoxication by industrial waste that was triggered by symptoms displayed by patients and offered an array of individual and public health services.[41]

This illustrates a sense of social accountability of health professionals and their spontaneous quest for more efficient ways to protect people's health. While such behaviour is not rare, rules and standardized procedures must be carefully worked out to ensure that conditions for such dual concern for the health of individuals and populations can be built into the health services delivery system.

Of course, a health territory has virtual boundaries and is not immune to external influences. Consumers cross borders in search of better services, making continuity of care and follow-up of individuals' health sometimes elusive. A "Tchernobyl cloud" can occur to interfere with the local environment, as can a wide set of social, cultural and economic factors. Organizational models for coordinated or integrated health action must take this reality into account.

ORGANIZATIONAL MODEL FOR INTEGRATION

Making the best use of the available expertise and resources for a given population living in a well-determined area will need a commonly agreed-upon mechanism among the main health partners or stakeholders, which entails coordination or integration. Coordination or integration may not necessarily be viewed in the same way by all the health partners, who may argue that they are only means to an end and that a sense of responsibility can be enhanced only by a certain degree of autonomy. Coordination and integration have their pros and cons.[42]

Table 1 compares the concepts of autonomy, coordination and integration with a number of issues in order to help clarify the position of partners in each case, the meaning of integration as used in the TUFH project, and possible evolution towards this integration.

Autonomy is a stage in which each partner works mainly independently and relates to others in specific situations. Coordination is a stage in which partners with different backgrounds function in an agreed-upon working relationship with a view to reducing unnecessary duplication and optimizing everyone's outputs.

The semantics around "integration" have been problematic. Ambiguities and misunderstandings have been numerous, particularly when dealing with organizational issues. Integration has often been taken to mean loss of freedom or specificity, disincentive to initiative-taking, uniformization and top-down planning. Alternatively, integration may be understood as reduction of undue overlap, control of wastage, synergy for more efficient response in solving health problems, appropriateness of interventions to address complex and multifaceted problems, and people-centred service meeting clients' expectations.[57,58]

Integration may be used to qualify a variety of actions that must be closely interrelated to ensure efficient patient management for a given disease or health problem.[43] It

	AUTONOMY	COORDINATION	INTEGRATION
HEALTH INFORMATION	**Circulates mainly within** a group of same partners	**Circulates actively among** groups of different partners	**Orients different partners' work** to meet agreed-upon needs
VISION of the HEALTH SYSTEM	Influenced by each partner's perception and possibly self-interest	Based on a shared commitment to improve the overall performance of the system	A common reference value, making every partner feel more socially accountable
USE of RESOURCES	Essentially to meet self-determined objectives	Often to ensure complementarity and mutual reinforcement	Used according to a common framework for planning, organization and assessment of activities
DECISION MAKING	Independent coexistence of decision-making nodes	Consultative process in decision-making	Partners delegate some authority to a unique decision node
NATURE of PARTNERSHIP	Each group has its rules and may occasionally seek partnership	Cooperative ventures exist for time-limited projects	Institutionalized partnership is supported by mission statements and/or legislation

Table 1. Comparing concepts of autonomy, coordination and integration

may also designate working arrangements in a health setting wherein different activities in a given health programme (e.g. maternal and child health, HIV/AIDS) are harmonized to optimize impact.[44]

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In the TUFH project, "unity" is defined as the measure by which different partners or stakeholders share a commitment to meet people's health needs through a system organized to optimally adhere to values of quality, equity, relevance and cost-effectiveness. In this context, privileged attention is given to integration of the whole range of individual health and population-based health activities, on the assumption that this integration will initiate a cascade effect and lead to a holistic approach in the health system at large. Here integration means that the different partners or stakeholders may indeed have to give up some of their current authority and prerogatives, but they will retain their identity and specificity and be offered new opportunities for development and expansion.

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Range of services

To properly address priority health concerns of the reference population in the identified territory, a range of individual health and population health activities must be designated and made available. The compilation of an appropriate mix of services can be based on different rationales. One such rationale is to refer to stages of the natural history of diseases, encompassing preventive, curative, promotive and rehabilitative services. Another would be to refer to the lifespan approach, focusing on the different periods of life from pregnancy to old age ("from the womb to the tomb"), or to an epidemiological approach focusing on prevalent diseases and handicaps, vulnerable groups or groups at risk, or a combination.

Selection of services can also be inspired by the identification of important public health measures, sometimes referred to as "essential public health functions." Here public health is defined as "organized efforts by society to prevent disease, prolong life and promote health."

Through eliciting expert opinion worldwide in a Delphi study, WHO obtained a consensus on these functions and grouped them into nine categories (see Table 2).

The above tentative classification shows the difficulty of circumscribing what public health entails, as already it does not represent a spectrum of discrete clusters of activities. For instance, the relationship between public health functions and personal care services is ill-defined, although a consensus was reached that personal health care services are part of public health functions to the extent that they provide population-wide benefits.[45] Besides, this statement supports the idea that integration of activities related to medicine and public health is not only possible but desirable.

- Monitoring the health situation
- Protecting the environment
- Health promotion
- Prevention, surveillance and control of communicable diseases
- Public health legislation and regulations
- Occupational health
- Public health services
- Public health management
- Care of vulnerable and high-risk populations

Table 2. Categories of essential public health functions

In a given territory, in societies where free entrepreneurship is the rule, the general picture is often one of heterogeneity of health services. Some services may be concentrated in certain areas or dispersed over the territory. Some services may belong to the private or public sector. Some are grouped under consortia, while others are largely isolated and autonomous. Similar services can be controlled by different public service administrations. Some services may be supplied in excess when regulated only by market principles. In contrast, in societies where governmental regulation and control exist, chances for overlap or underrepresented services may be minimized. In any case, for optimal use and coordination or integration of services, an inventory of all services available in a given territory should be kept up to date and information should exist on the actual performance of these services, possibly through appropriate quality assessment mechanisms.

Links

In general, harmonization of a wide range of activities of different professional groups, even when genuinely moved by the same will to serve people's health needs, does not happen easily or naturally. It must be organized.

Let us consider the most favourable situation where the essential health services for a reference population can be provided by the same health setting, for instance, a health centre. In this case, a mechanism may be in place (see Table

3) whereby health data regarding the population under study (A) are being routinely collected with a view to obtaining a comprehensive appreciation of the health status and health risks (B). Further identification and sorting of health needs for priority-setting would give rise to a range of appropriate services (C and D).

Reference population (A)
Vital statistics/health data (B)
Health needs and priorities (C)
Range of appropriate services (D)
Distribution of roles (E)
Coordinated/integrated service delivery (F)
Impact of services (G)

Table 3: Steps and links in health service development

The range of appropriate services may cover a spectrum of curative, preventive, rehabilitative and promotive care and may target individuals, families and the entire community, or subgroups of the community such as schoolchildren, workers, the aged, the handicapped, the unemployed and patients with chronic illnesses.

These services would be carried out by a mix of health personnel: doctors, nurses, social workers, environmentalists and others (E). Coordination or integration of their work is necessary to ensure that the objectives of the health centre relative to quality, equity, relevance and cost-effectiveness are optimally met (F and G).

The links between certain sets of activities must be clearly spelled out. For instance, in the context of continuity of patient care, a protocol will advise on the most efficient contribution of different types of health personnel, with instructions for complementarity and minimal overlap, as well as maintenance of a unique patient or family record.

In the case of a community health programme, the links between activities must be even more carefully planned. For instance, for a diabetes control programme, the following services should be well interrelated: nutrition, endocrinology, cardiology, physiotherapy, nursing and social support. For a violence-control programme, many more interventions would be required to act on a wide host of determinants, from personal health to the community health level.

Emphasis should be put on mechanisms to ensure mutual support and reinforcement between activities geared towards individuals and the community at large.

Community-oriented patient care (COPC) means understanding the patient's problems in the context of his/her family and community and acting on factors in the family or community that bear on the health of an individual.[46] The patient record encompasses health data affecting an individual or his or her family, with an assessment of striking community health events. COPC is an example of an approach creating links between individual and community health.[52] Supporters and opponents have expressed their opinions on the feasibility of this approach.

Individual and community health services may be intertwined. For instance, in child health clinics mothers may be advised on health risks incurred with drinking water, waste disposal and the like. During a sanitation campaign, home visitors may provide either direct health service for minor ailments or refer patients to the appropriate level for clinical care. While coordination can be achieved through goodwill and a *modus operandi*, integration requires a formalized process in which actors agree to serve within an organizational model that ensures better convergence of their efforts to address the cause of quality, equity, relevance and cost-effectiveness. Some rightly see community-oriented primary care as the cornerstone of health care reform.[47]

The formalized process of integration should be depicted by a diagram or flow chart to make clearer everyone's commitment, to plan joint work and assess performance. An organizational chart should show the range of services proposed, the way they should interrelate and the division of labour among different categories of the workforce. On a weekly timetable, for instance, these elements would be easily identified.

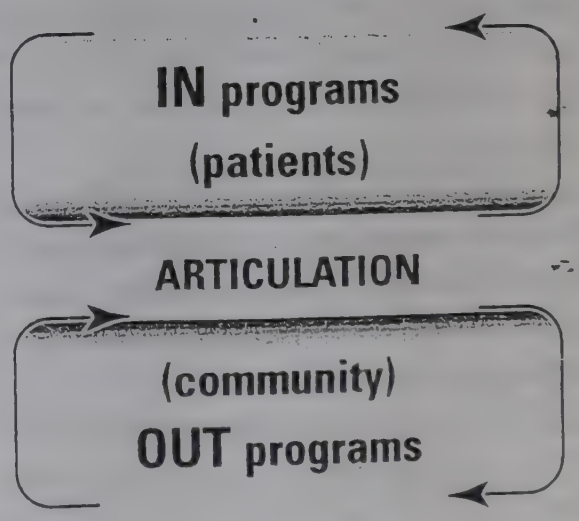

Figure 9. Articulation among programmes

Meetings and shared techniques and records can be used to stimulate the integrative process. For instance, in outpatient clinics, selected patients could be identified as "markers" to

facilitate follow-up on priority health concerns in the community. The technique of the markers or "index cases" has been used to trigger specific community-wide intervention programmes and as a means to link medicine and public health.[48] At a certain point, clinical data and community health data are reviewed jointly for a comprehensive picture of the reference population's health, an eventual readjustment of proposed services and a reinforcement of the integrative process. Such joint reviews can take place at regular meetings with principal health actors or by more sophisticated means of health information management.[49] Figure 9 shows how data from patient care and from community health programmes feed into regular "articulation" meetings once used in integrated health centres in Algeria to help plan appropriate services to meet people's needs.[50]

The example of a "self-sufficient" health centre with a reference general population as a target is far from being the rule. In remote areas, mostly in developing countries, a health setting may assume sole responsibility for a wide array of health services and can therefore more easily develop integration. Only in exceptional circumstances have integrated health settings with population responsibility been institutionalized on a nationwide basis, either under the influence of a strong ideological leadership (e.g. Cuba) or with the assistance of external support.

Generally, incentives to work in an integrated mode are few. The division between individual health and population health, the surge for specialized service, the rivalry among health professions, the competition between public and private sectors and within the private sector contribute instead to widespread fragmentation. Models must be developed to counteract this trend and suggest working patterns for convergence and integration of the work of the stakeholders involved, and proper incentives must be proposed.[51]

In most instances, the health care delivery system works as an "open circuit" wherein different health settings (e.g. health station, health centre, general practice office, district hospital) cover only a part of the range of health services needed by the reference population.

However, within a pluralistic system and even in the absence of a formal coordinating or regulatory body, some health settings may yet initiate an altruistic and needs-based approach. The case of health-promoting hospitals demonstrates links for integration, either to ensure continuity of patient care from hospital to home[53] or to assume a social responsibility in facilitating access to health care for those who most in need in the local community.[54]

Also, some health maintenance organizations or large health plans offering a wide spectrum of services to their enlisted clients may, under principles of managed care or for humanistic reasons adopt a holistic vision of their clients' health. The health professions may also widen their perspective of work beyond a narrow area of competence and engage in collaborative ventures to better meet people's needs. For instance, clinicians may spare time in community-based and population-wide programmes, either on a contractual basis or as a more routine pattern of work. Primary health care teams, including general practitioners or family physicians, are usually open to creating links with several health partners to promote comprehensive and integrated health service.

In some countries, national policies exist to allow general practitioners or family physicians to assume coordinating responsibilities in the health service delivery service, for instance, by acting as a "gatekeeper" to screen access to specialized care and provide comprehensive primary care. The principle of a patients list (close to the principle of a reference population) and the delegation of authority for the use of health services in a given area, such as the United Kingdom, are important supports to general practitioners' offices to play an active role in creating unity in the health system.[55]

The establishment of divisions of general practice in Australia to explore ways to better coordinate care for certain categories of patients is also an interesting move in the right direction.[56]

Organizational models for integration will vary with the political and socioeconomic context. However, we would submit that such models should demonstrate the following characteristics:

- *Needs-based.* For a given reference population in a circumscribed territory, health services should be proposed with a view to responding to health needs of individuals and the population.
- *Partnership.* Several health partners and health service providers should be mobilized to deliver a minimal range of needed services, with public benefit predominating over vested interests.
- *Regulatory mechanism.* Stakeholders or partners should accept that services intended for a given population be planned to avoid undue overlap, fill gaps and ensure productivity to meet imperatives of quality, equity, relevance and cost-effectiveness.
- *Rewards.* The model should foresee incentives (material or otherwise) and attractive working opportunities to stimulate and support a process leading to

complementarity or integration in partners' work.

- *Information system.* Health data should be available to all partners in order to enable them to assess health situations and the impact of health interventions. As far as possible, their respective contribution to the integrative process should be documented.

COMPREHENSIVE HEALTH INFORMATION MANAGEMENT

Can proper management of health information serve as a glue and facilitate unity for health?

Availability

We may wish to think that if, for a given reference population, wide knowledge were available on the health situation – on the existence of relevant health risks, the vulnerability of subgroups, morbidity and mortality trends, the health resources available, and the level of health expenditures – better decisions would be made in the health care delivery system. Access to and use by main stakeholders or partners of these health data would in principle allow them to assess the extent to which the values of the "health compass" – quality, equity, relevance and cost-effectiveness – are being fulfilled and integrative processes are operating. Relevant tracers would be chosen to that effect. For instance, tracers in quality could refer to certain causes of mortality and morbidity, and client satisfaction; tracers in equity could monitor access to basic health services for all and particularly vulnerable groups; tracers in relevance could assess whether priority health issues are given privileged attention; tracers in cost-effectiveness could report on the most appropriate decisions in the use of health technologies and drugs.

Obviously, advocacy for a comprehensive health service delivery for a population calls for a comprehensive health information management system.[59] Table 4 suggests functions that such a system would fulfil.

Health data are usually not lacking even in the most deprived contexts. Often, health settings provide more data than can be processed. Clinics, health centres and hospitals accumulate huge numbers of patient records that could be reviewed as to reasons for consultation, health problems, outcome and other parameters. Epidemiological records are usually available, whereas data on health risks, health behaviours, and environmental sanitation are irregularly obtainable. Efforts must be made to define the minimal sets of data required to run a health service to improve quality, equity, relevance and cost-effectiveness in health for the reference population and ensure that those collecting data

- Collection of health data on the reference populations from various sources
- Routing of health data towards a central node located within the reference population
- Aggregation of health data
- Circulation of health data digests to main stake holders
- Use of health data for decision-making to pursue health values
- Performance assessment

Table 4. Functions of a comprehensive health information management systemwill directly benefit from their analysis for optimal decision-making.[50,51]

Use by all

One challenge is to set up a systematic aggregation of clinical and epidemiological data so that the knowledge of personal health problems can be used to design population-wide intervention programmes. Conversely, the knowledge of health risks within a given population can assist the health services providers to optimally use available resources to support clients and their families. Information sharing can become a powerful booster for integration, as the circulation of a common knowledge base among key partners may encourage them to assess how they can best contribute to people's health. Priorities may be better highlighted and gaps in health service delivery as well as new opportunities of work may be better identified.

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From clinical care to community health

A gastroenterologist in a middle-size town wonders how data on intestinal polyps, one of his specialty areas, could be systematically collected from his colleagues established in the province and treated by a central epidemiological unit to identify local risk factors in the malignant evolution of polyps and help decide on best practices for prevention, detection and follow-up. He presumes that tele-informatics would reduce the burden of data transmission and that accumulated clinical information from different sources would help shape useful community health promotion programmes.

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Health data from different sources would be sent to a central node located within the reference population (e.g. a district) for analysis, and health digests would be made available to each principal partner or stakeholder (i.e. policy makers, health managers, health professionals, academic institutions and consumers). Measures should be taken to ensure that confidentiality of personal health data is protected. The assumption is that with the ensuing transparency and easy access to information on the health situation and on health operations conducted in a given area, stakeholders will have opportunities to readjust their work for improved performance, with the aim of fulfilling people's needs.[49]

If consumers, for instance, were provided easy access to useful sets of health data, they would be in a better position to make informed decisions regarding the protection or restoration of their own health.

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An informed client can act responsibly

- *In some countries, individuals keep their own health logbook in which any significant health event is recorded. They bring the logbook along when consulting. The logbook also draws the consumer's attention to prevalent health risks in certain age ranges and provides advice on desirable lifestyles.*
- *Consumers may be organized in groups to review local data on health status, health risks or on quality in health services, which gives them a basis to ask for services, exercise pressure on health care organizations or initiate support mechanisms for certain health problems or handicaps.*
- *Associations of patients with HIV infection or AIDS and patients with other chronic diseases are vivid illustrations of situations where well-informed individuals take an active part in their health.*
- *The individual informatic health record (i.e. the "smart card" which resembles a credit card) is another example of ways to facilitate people's empowerment. The potential of such a card, although they are still largely experimental, can be tremendous. It would not only provide handy access to one's own health record but also obtain updated information from a central data bank on health events or resources relevant to one's own situation. For instance, people with a certain chronic disease would be able to interact through telecommunications with other patients with a similar disease on the best ways to cope with the ailment.*

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Telematics and computer technology can accelerate the evolution towards a comprehensive health management system for the whole reference population, with a minimal burden for stakeholders contributing to data input.[52] The system would allow evidence-based decisions for resource allocation according to people's needs. It should encourage a management style in which everyone has access to relevant information and can responsibly decide to take a more productive and integrated approach to work.

However, such information systems may raise resistance as transparency may cause a shift of power among stakeholders and reveal a lack of accountability on their part. Reluctance may therefore be expected in information sharing between primary health care and reference centres, between health professionals and patients, between the public and private sectors, among health specialists, and between medicine and public health services. Confidentiality issues must also be addressed.

Although maintaining a comprehensive health information management system requires a significant level of expertise and resources, the power of information and the collaborative patterns it encourages will inevitably prevail. Rapidly growing countries, such as Malaysia, have made it a national policy to use information technology to provide important health stakeholders, providers as well as beneficiaries, with a flow of data with a view to maximizing the use of health resources and creating opportunities to develop convergence of interests in their health system.[53]

ealth professions development is at the core of a successful volution towards unity in health services. While health rofessions practice and education must adapt to new pproaches towards health delivery, they can in turn significantly influence the process of change.[64]

The domain of health professions development illustrates the benefits of a systems approach. The optimal use of human resources in the health field results from a coordinated sequence of elements such as a clearly defined mandate and operational model of health settings where health professionals are expected to function; properly defined roles and scopes of responsibilities of health professionals; adherence to guidelines for good practice; appropriate working conditions and motivation at work; and a relevant and efficient educational system.

Each action is influenced by others. It is therefore opportune to understand the interrelationship between organizations or institutions that carry the major responsibilities in health professions development and to encourage productive interaction. Figure 9 points out, for instance, the desirable network of relationships between changes in health care, medical practice and education to make steady progress towards a commonly agreed-upon goal, in this case the WHO goal of health for all.[6,7]

IMPLICATIONS FOR PRACTICE

What will health professionals do differently in a working environment where the principles of the TUFH project are applied?

New roles

If the roles and responsibilities of health personnel are to be influenced by people's health needs and expectations and by essential features of an integrated approach towards health services delivery, new opportunities and challenges for the health professions should be expected.

Currently, models of excellence in the practice of health professionals too often exemplify specialized expertise. The public, largely responding to influence from the media, tends to revere those who master esoteric high-technology procedures, while it gives less recognition to those who apply their skills in a holistic approach to health and disease, such as generalists, and virtually ignores the work of the guardians of population health – the public health professions.

This situation has much to do with the visibility of impact. Short-term and immediately demonstrable effects, such as in lifesaving procedures, serve more often as yardsticks of achievement and prestige than action aiming at long-term impact, such as changing lifestyles. Actually, the prevention of smoking and many other preventive programmes are also lifesaving but are not usually perceived as such by the public, due to the long time that elapses between action and impact. While the glory of medicine is in combatting diseases or disabilities, the glory of public health is in preventing their occurrence. Generally headlines privilege the former over the latter.

Obviously the contributions are judged according to different scales, not only by the public but also by the health professions themselves. With better-informed people and critical appraisal of comparative possibilities and limitations of medical care and health-related interventions, the image of the health professions is likely to shift. As it becomes more aware of the wide array of health determinants, such as those related to the degradation of the environment, the public will start to acquire a more balanced understanding of causation of health and ill-health and will recognize the values of a variety of measures, beyond medical and biotechnical procedures. This will ultimately enhance the image of health professionals who use a mix of skills to make an efficient and lasting imprint on health through a range of actions, including advocacy, education and social activism.

The status of "generalists" will rise as their capacity to coordinate many of the individual and community health services and interact with other health actors to sustainably improve quality and equity becomes known and appreciated. With the emergence of more and more specialists and specialized services, the public – despite being better informed on health matters – will need the assistance of "brokers" – such as generalists – to help make the best decisions for the protection or restoration of their health. Also, under pressure for cost-effectiveness and equitable allocation of resources and in the perspective of an integrated health system, the increasing recourse to generalists appears to be widely favoured.

The question is: "Who is a generalist?" Is a generalist a member of a defined category, or does being a generalist mean being able to comprehensively understand what may determine health and disease and to help individuals, families and communities obtain an appropriate response to their complex health needs? A general practitioner, a family physician, a nurse practitioner, a community health worker – anyone working in a primary health care team would qualify.

But to some extent members of any health profession should display such an ability, as they aim to respond to the needs of individuals and populations alike by embracing the range of physical, psychosocial and economic factors influencing their health. This would also imply that health services should be developed by making the best use of talents and resources, possibly through integrated processes. It also requires that the health professions put aside their sectoral interests in order to benefit those needing help and compassion.[65]

In the future, it is likely that the health professions will be expected to display aptitudes in their specific domains of recognized expertise but also to understand their relative position on the health chessboard and therefore the necessity to coordinate their work with other fields of expertise in order to provide sustainable protection of individuals, families and communities at large.

- Care provider, who considers the patient holistically as an individual and as an integral part of a family and the community, and provides high-quality, comprehensive, continuous and personalized care within a long-term relationship based on trust.
- Decision-maker, who chooses which technologies to apply ethically and cost-effectively while enhancing the care he or she provides.
- Communicator, who is able to promote healthy lifestyles by effective explanation and advocacy, thereby empowering individuals and groups to enhance and protect their health.
- Community leader, who, having won the trust of the people among whom he or she works, can reconcile individual and community health requirements and initiate action on behalf of the community.
- Manager, who can work harmoniously with individuals and organizations inside and outside the health care system to meet the needs of patients and communities, making appropriate use of available health data.

Table 5: The five-star doctor

The "ideal" health professional would possess a balance of *"content"* expertise and *"linkage"* expertise. The "content" expertise refers to mastery of methodologies and tools in a given technical area, while the "linkage" expertise refers to the capacity to interact with practitioners of other technical

areas in the wider domain of health and developme
Generally speaking, steady progress in the wider co
sustainable development, of which health is a part,
achieved with the support of a cadre of people with
in both "content" and "linkage."

In a health service based on people's needs and
integrated health approach consistent with the value
quality, equity, relevance and cost-effectiveness, wha
be the ideal profile of a health professional? The profil
"five-star doctor," displaying five basic sets of aptitude
serving as a symbol of excellence, could fit any other h
profession. The five-star profile expects someone to be
care provider, a decision-maker, a communicator, a co
nity leader and a manager. Table 5 explains further.[66]

The portrait of the "five-star doctor" has been reta
as a reference by several professional groups. General
practitioners or family physicians have generally seen in
good illustration of what they now do, or what they aspir
do. In most instances, however, their reference is to a lis
patients and families and not to a general population. Th
indicates that their position relative to the "fourth star" –
community leader – needs strengthening.

The World Organization of Family Doctors (WONCA) a
WHO jointly recognized in 1994 that:

> The family doctor (general practitioner/family physicia
> should have a central role in the achievement of quali
> cost-effectiveness, and equity in health care systems.
> fulfill this responsibility, the family doctor must be highl
> competent in patient care and must integrate individua
> and community health care.[9,71]

We see that general practitioners and family physicians largely envision playing a significant role in meeting the health challenges mentioned above, and recognize that they must adapt to play a more proactive role in the coordination of individual health and community health services in a given population – which is at the core of the "Towards Unity for Health" project. This general aspiration has been confirmed by representatives of medical associations worldwide, namely in Africa[67], Asia[68] and North America.[69]

As mentioned earlier, the "five-star" profile would suit any primary health care team member committed to working in a comprehensive and integrated health service delivery system – doctors, nurses, dentists, allied health personnel – although they would give different emphasis to different "stars." Pharmacists have also added their voice to the choir, and have suggested adding two more sets of aptitudes to make it a "seven-star" profile.[70] It is our view that, to a certain extent, even specialists could qualify by following a similar

pattern when trying to adapt to requirements of a health system based on people's needs.

With a movement to establish more efficient health systems and a tendency to value integrated approaches for that purpose, new practice patterns should emerge and new roles for health professionals should be delineated.[72] With the trend for improved transparency and circulation of health data to assess adherence to health values, particularly cost-effectiveness, certain working patterns will be favoured, particularly multidisciplinary teamwork at primary care level, as well as teamwork across the health service delivery system.

Either new professions will be created to fill gaps, or, more likely, existing professions will adapt to benefit from emerging opportunities. If and when the change towards more integrative processes becomes popular, the health professions may demonstrate their interest in adapting. There might be several motives for this: genuine interest in becoming actors in the change process; eagerness to protect most of their prerogatives by strategically surrendering some of them; and a desire to position themselves to benefit from a new situation to grow and expand. Experience has shown that health professions can adapt not only to applying new procedures but also to making important shifts in working styles, as exemplified by medical specialists in the United States of America turning into family physicians when opportunities arise under managed-care schemes.

In any case, needed competences and skills should be identified and checked and certification granted by efficient continuing medical education schemes. A variety of educational interventions may be considered for imparting new skills and possibly achieving substitution and complementarity within the health workforce, from the perspective of a service run according to TUFH principles.

Rewards

The health professions will find their participation in health system evolution satisfactorily rewarded if there is due recognition of their contribution and if their professional standards are enhanced. History has shown that societies are not sustainably transformed by generous ideas only. To make a durable input on people's quality of life, good ideas must be translated into well-grounded organizational patterns of work, with optimal support from the workforce.

Full adherence of the health professions to a new philosophy of work should result from their active contribution towards shaping it. Rewards or incentives for the health professions to work towards creating unity for health could be of different kinds.

Adherence to a code of ethics

As they acknowledge its value, the health professions may wish to officially recognize that the application of a holistic approach to restoring and promoting health of individuals and populations in line with the values of quality, equity, relevance and cost-effectiveness is a duty and an important expression of their code of ethics. They may wish to demonstrate their commitment publicly by taking an oath.

For centuries, in several parts of the world, the medical profession has taken the Hippocratic Oath as a reference for their work. In some countries, freshly graduated physicians can obtain a license to practise only if they have formally sworn, by a public declaration and a written statement, that they will follow the rules proposed by the illustrious Greek physician of the fifth century BC.

However, while some think the Hippocratic Oath is still relevant, voices have been raised to question its completeness and adequacy to modern times in view of unprecedented challenges that people and societies face worldwide.[73,74,75] There have been suggestions to consider an oath not only for physicians but for all health actors that would more appropriately reflect values such as those captured in the TUFH approach.

Recognition and status

The human factor and human resources are essential for any successful and sustainable change in society. In the health field, the special contribution of the health professions must be appropriately acknowledged and the merit of working in the context of a health service based on people's needs should be fully recognized. A practice oriented by these principles should be recognized formally, possibly through an accreditation procedure. Standards and criteria could be developed to guide and ultimately assess the manner in which a health profession meets the obligation to deliver high-quality health service in an equitable and cost-effective manner. Continuing education and advisory services to help comply with the standards should be made widely available.

For the sake of both the health professions and the public's protection, it is useful to specify, possibly through legislation, the extent to which the health professions should be made accountable to society with respect to the improvement of quality, equity, relevance and cost-effectiveness.

Motivation at work

Working patterns inspired by the principles imbedded in the TUFH project should be made attractive and a source of professional satisfaction. Therefore, the health professions should be made aware of the extent to which they contribute to

progress towards the improvement of health service delivery and health status. Each health profession should feel that it is integral to a service driven by the values discussed above and understand its position on the health-sector chessboard. They will also derive professional satisfaction from becoming aware of their capacity to influence health determinants and to enjoy the opportunities offered by working in an open system, beyond the usual confines of a given professional discipline, allowing for eventual expansion, professional mobility and personal development.

Material incentives

Material incentives should be provided to the health professions to proportionally compensate their efforts in serving a health system that endeavours to meet people's needs. Working conditions conducive to facilitating the creation of unity for health must be made available, particularly by providing facilities and equipment for optimal management of health resources and use of health information.

The issue of financial rewards must be addressed, both from ethical and pragmatic standpoints. Fundamentally the health sector must be guided by public benefit, not by profit-making principles. Of course, situations where health professionals working in hardship conditions are underpaid, or where health professionals employed by the public sector remain unpaid for months, must be remedied before they are asked to put forth additional effort in health service delivery. While career choices seem to be increasingly influenced by the balance of desires – the size of the salary weighed against the expected satisfaction at work – it is important to explore with an open mind how the health professions relate to money.[76]

Independent fee-for-service payments and centrally controlled salaries are two extremes on the scale of remuneration schemes that have shown their limits. While the former does not deal well with the cause of equity, the latter is often correlated with substandard quality in health service. To best serve the health of the public, both individually and collectively, it is probably fair to state that neither of these remuneration systems would be fully compatible with a health service guided by "Towards Unity for Health" principles. Mitigated modes of payment would need to be worked out in observance of current sociocultural value systems, combined to different degrees: fee-for-service, salary, capitation fee, remuneration by activity, remuneration by result. If rewards must be given to ensure that health professionals fulfil all obligations anticipated in a given professional profile (see for instance the areas of responsibility exemplified by the above-mentioned "five-star doctor"), it is likely that multiple sources of funding would contribute towards remuneration.

However, while the TUFH project aims at reducing fragmentation in the health system, would it not be counterproductive to advocate fragmentation in the payment system?

The contradiction would be apparent only if different sources of remuneration were channelled through a single coordinating and regulatory body to respond to comprehensive health needs of a reference population. The remuneration of health professionals can be dealt with meaningfully only if considered in the wider context of health financing policies and related to initiatives to spur mutually supportive ventures between privately induced funding (users fees, various insurance schemes) and public moneys.[101]

IMPLICATIONS FOR EDUCATION

Social accountability of educational institutions

Although the education of health professionals can be provided by professional associations (i.e. in the case of continuing education or postgraduate education) or by health service organizations (i.e. in the case of in-service training), the prime responsibility for preparing future generations of health professionals lies with educational institutions. In the context of our reflection, we will consider that health professions educational institutions (i.e. medical schools, nursing/midwifery schools, schools of allied health personnel, schools of public health, schools of pharmacy, dental schools and so on) currently assume the three basic functions of education, research and service delivery. Episodically some may also contribute to policy design and formulation on a health sector-wide basis.

The term "educational institution" is used here to denote an institution with a recognized duty to prepare the workforce that society needs. It is also assumed that the mandate of the educational institution is to produce health professionals possessing a specific corpus of skills, enjoying a degree of autonomy in the planning and organization of their work, and capable of delivering a spectrum of services responding to people's needs. In support of such a mandate, educational institutions would be expected to conduct research to create new knowledge and contribute towards establishing innovative practice patterns. In doing so, they would make a special contribution to health system changes while fulfilling their duty to anticipate the contexts in which future graduates will work. In the case of medical schools, for instance, this is particularly needed, as an average of 15 years may

elapse between student intake and service delivery by a fully qualified physician.

Educational institutions very often serve as a reference to health professionals in practice, who follow their guidelines and recommendations or use eminent professors as role models. This is an additional reason for educational institutions to be aware that they can and should influence the health system. Their contribution to that effect will depend on their ability and resources, as well as on their capacity to build productive partnerships with other forces in society.

Their potential is variably used, however. The degree of their social responsiveness may be grouped into three categories.

Neutrality

This is unfortunately a common situation, in which educational institutions carry out their education, research and service delivery functions with little concern for adapting them to the changing needs of individuals, families or the community at large. Under the cover of academic freedom and the search for excellence, they pursue scientific and technological objectives with little consultation outside of academic circles and without taking account of the most prevalent and urgent health issues. Their work is assessed mainly by peers and has little direct and immediate relevance to people living in the surrounding community.

In the developing world, this attitude has led to painful situations. For example, we know of a medical school that proudly announced its progress in sophisticated brain surgery while its infectious diseases department was not able to prevent deaths from cholera resulting from a contaminated well about 200 metres from the operating room.

In many developing countries, medical schools and other health professions schools have been established according to models in the industrialized world and too many of them have not reviewed their mandate according to the specific requirements of their environment. Sometimes they remain more conservative than the mother institution.

It is striking that in many countries, developed or developing, poor basic health service delivery coexists with sophisticated biomedical research. Institutions that fail to respond adequately to local needs are justifiably labelled "ivory towers."

Reactiveness

In this situation, an increasing number of educational institutions are aware of priority health needs in society and take the initiative in reacting responsibly. Their mandate is explicit as to improving people's health, facilitating universal access to health care and contributing to meeting new challenges in the health system. An example of the expression of this commitment might be strong input to community health action, with staff and other resources either from a specialized department or, better, from several departments throughout the school.

Such schools adapt their educational programmes to better meet people's needs and expectations. They assess and update curricula regularly; learning opportunities are offered early and throughout the curricula to ensure proper exposure of students to the harsh reality of life at community level; students are selected from all segments of the community, particularly the disadvantaged. Such schools facilitate collaborative ventures with health authorities and the community with a view to improving the relevance of the education, research and outreach programmes. These schools are prepared to react to people's evolving needs and to changes in the health system. Those organized to make systematic use of health status information in the community react promptly; others take longer to react and readjust.

Proactivity

This is the category to which we would like to see most educational institutions belong. It is characterized by an attitude of anticipation. Here, the school uses its talents and resources as well as its capacity to collaborate with other actors to make an authoritative situation analysis of the health sector, to identify the future challenges in the health sector and to contribute to designing and developing innovative approaches to meet these challenges.

A comprehensive understanding of the evolution of the health system offers opportunities for an educational institution to hold a more responsible position on the health chessboard. For instance, the medical school's responsiveness will not be limited to implementing an ideal educational programme to prepare the next generation of doctors, but will encompass action to ensure that the new breed of graduates will find a working environment consistent with the education they have received. This implies that the medical school, like any other producer of a commodity, studies the market for its products and contributes towards creating favourable conditions for its reception (in this case, employment of its graduates), consistent with society's expectations.[77] This view is consistent with the Declaration and recommendations of the World Conference on Higher Education organized by the United Nations Educational, Scientific and Cultural Organization (UNESCO) in 1998.[88]

A definitive indicator of proactivity would be to conduct

health system research with a view to providing a scientific base and appropriate methodologies for implementing a TUFH project.

Concepts of social responsiveness/social accountability

Of these three positions, proactivity most closely approaches the concept of social responsiveness. *Social responsiveness* is a measure by which a school responds to societal needs. For instance, a school may be concerned about whether its graduates perform as effectively as expected when they are in a position to serve society; it adjusts its programme to reflect the lessons it learns. It may also examine the extent to which research results have an impact on priority health issues, or it may question the validity of the health services it delivers in serving as models for health care providers. So a socially responsive school perceives the needs of society and reacts accordingly.

The concept of *social accountability* goes beyond the concept of social responsiveness, as it implies that the school consults society to jointly identify priority health issues and expectations. The school then seeks evidence that it addresses these issues and expectations with a view to obtaining short-term and longer-term benefits, in part for the local community and in part for the country as a whole or the international community.[5] Educational institutions should voluntarily be socially responsible, but they should also expect to be held to account by society for what they do, particularly if they are supported by taxpayer funds.[85]

While academic freedom must be protected to allow creative minds to open new fields of investigation without undue interference and prepare society to face new challenges, accountability to society should be defined and delineated. Academic institutions should take the initiative by suggesting ways to revise their mandate in light of the evolution of society and the health system, and readjust their scope of work accordingly.[84,85,87] In doing so, they will set their own framework and reference points for assessment of their social accountability and lessen any undue pressures from financing or donor agencies or other external bodies.

Social accountability can be assessed by means of four essential reference points, described earlier as the fundamental values on which health system development should rest: quality, equity, relevance and cost-effectiveness. A taxonomy of social accountability can be developed by defining the degree of adherence to these values in the three basic domains of institutional responsibility: education, research and service. Such a taxonomy can become a "social accountability grid" to assess the extent to which these three domains contribute towards bu a health system that is relevant to the needs of the community or nation and provides high-quality healt that is cost-effective and equitable (Fig. 10).

	DOMAINS		
VALUES	Education	Research	Se
Quality			
Equity			
Relevance			
Cost-Effectiveness			

Figure 10. The social accountability grid

The taxonomy can be further developed to capture t evolution of the school towards the highest phase of soci accountability, that of making an impact on the health syst An expanded grid would therefore accommodate three phases, designated as "planning," "doing" and "impactin phases (Fig. 11).

	DOMAINS AND PHASES								
VALUES	Education			Research			Service		
	Planning	Doing	Impacting	Planning	Doing	Impacting	Planning	Doing	Imp
Relevance									
Quality									
Cost-Effectiveness									
Equity									

Figure 11. The expanded social accountability grid

The most modest commitment is the *planning* phase, in which a school demonstrates that it intends to undertake socially accountable actions – by means of the content of its mission statement, or the way departments are organized, or the way resources are allocated. The *doing* phase involves more commitment, since here a school shows that it is implementing the planning phase: restructuring has taken place, staff time has been used, resources have been spent or relevant activities have been carried out. Finally, in the *impacting* phase, the school demonstrates its contribution to important and sustainable changes in the health system as a result of its capacity to advocate these changes among policy makers, health care organizations, health professionals or the community of users. The chances of having significant impact are greater if partnerships are initiated with these actors from the "planning" phase on.

The social accountability grid is now composed of 36 cells. For each cell, general indicators can be proposed that can be adapted to the local sociopolitical context, as well as criteria for quantifying the degree to which the indicators are present.[5] Such a grid has been examined by an international

ple of medical schools and its usefulness field-tested as a to assess, stimulate, steer or monitor the response of dical schools to society's needs.[76]

osting social accountability through coalitions

e way to improve the school's response to society's needs to help the passage from intentions to deeds and from eeds to effects. The progression along this continuum is ustrated by the sequence of the "planning," "doing" and impacting" phases in the domain of education with respect o equity, as proposed by the social accountability grid applied to a medical school (Fig. 12).

In too many cases, the education function is limited to the *planning* phase, as shown in Fig. 12. In some cases, it encompasses the "doing" phase. But society expects results: the most meaningful phase for it would be epitomized as: *"The health status of the underserved is improved and the gap between privileged and underserved is narrowing."* In examining the "impacting" phase in the three functions of education, research and service with respect to equity as shown in Fig. 13, we would observe an interesting summation of the school's possible contributions that would come even closer to the outcome expected by society.[79]

Considering the educational institution's mandate and knowing that it does not bear the main responsibility for organizing and delivering health service, we may argue that the cumulated "impacting" phases are as far as the school can go in responding to society's needs. An important lesson learnt is that the school can make an impact on health service delivery and on people's health status if it is able to coordinate its own actions and establish collaborative links with other partners or stakeholders in the health sector. This would be an outstanding contribution to "unity" for health.

A school's education, research and service activities must reinforce each other by addressing complementary facets of a common issue. For instance, in medical schools the value of integrating the principles and methods of preventive medicine and public health in teaching the clinical sciences cannot be denied, but considerable value would be added if medical schools were to complement this educational innovation by such concrete means as doing research on guidelines for good practice and recommending ways to reward good practice in the routine service delivery of practitioners. The combination of education, research and service innovations in this issue is likely to have more impact than innovations in any single area. Likewise, if a medical school is committed to contributing towards reducing society's burden of prevalent or re-emerging diseases, for instance, it will have to work in partnership with other actors who influence disease control. The medical school's role in strengthening tuberculosis control is an example of this.[80]

- The impacting phase in *education*: The medical school has taken the initiative to ensure that it has produced physicians who can maintain their skills and deliver health care to the underserved.
- The impacting phase in *research*: The results of research on equity in health care delivery are disseminated and the medical school takes initiatives to ensure that they are considered by the appropriate group for policy development and decision-making.
- The impacting phase in *service*: Based on experience and evaluation of different approaches to health service delivery, the medical school has taken the initiative to influence appropriate groups for policy development and decision-making to ensure that health care to the underserved is promoted and encouraged.

Figure 13. Summation of "impacting" phases in the social accountability grid

In the more complex situation of acting on important determinants of ill health, such as poverty and inequity, the

The "planning" phase:	The curriculum is designed, and updated at appropriate intervals, to emphasize the provision of care to the underserved.
The "doing" phase:	Throughout their education, all students and graduates are exposed to a variety of learning opportunities in which health care to the underserved is practised. The performance of students in this activity counts in their overall evaluation.
The "impacting" phase:	The medical school has taken the initiative to ensure that it has produced physicians who can maintain their skills and deliver health care to the underserved.

Figure 12. Social accountability in education for equity

requirement for partnership in action is even greater. The initiative taken by WHO and UNESCO to study and promote the role of universities on the health of the disadvantaged is an example of faculties of medicine and health sciences seeking associations with sister faculties (e.g. political and social sciences, including economics) and extending collaboration with local governments, professional associations and communities to have a sustainable positive impact on the health of the most deprived in society.[81] The more diversified and productive the alliances an educational institution is able to build internally and externally, the more it is likely to improve its social responsiveness.

Improving by assessing

The combined effects of high interdependency of organizations, institutions and individuals in any modern society, the mounting quest to use moral and professional references in management practices and the wide availability of information on any institution's performance will spare no educational institutions in the future from being fully transparent in their contribution to people's well-being. In this perspective, they should subject themselves to introspection. They should take the initiative to set standards of social accountability and propose methods to assess it and improve on it. If they fail to be proactive, they may be pressured by external forces to act.

Social accountability of medical schools, for instance, should be seen as a moral obligation, as binding as the Hippocratic Oath for the medical profession, and therefore fully recognized in the medical school's mandate. But more importantly, social accountability should be seen as an opportunity to broaden the scope of professional expertise and influence on the health scene. National accreditation systems for medical schools, where they exist, should consider adapting the current framework to incorporate a social accountability component. Examining the functions and structure of the medical school is the main concern of known accreditation systems, with little questioning of the relevance of the products (graduates, research results, services) and their impact on health service and health status.

For instance, indicators of the quality of medical education tend to focus on areas such as the content of principles taught, the nature of educational and learning methodologies, the availability and quality of staff and equipment, the richness of libraries, etc., and leave almost untouched areas such as career choices of graduates as compared to society's needs, work performance of graduates and contribution of medical schools to continuing education programmes, etc.

Introducing the social accountability component to the accreditation of educational institutions will push th beyond the process of carrying out sets of actions t questioning the impact of these actions on the healt delivery system and possibly on the health status of t people the institutions are supposed to serve. In doin educational institutions will set up a model, among oth health institutions and organizations, in submitting the selves to an appraisal of their capacity to develop heal services based on people's needs. Educational institutio with this mindset would be ideal partners in a TUFH pro

In practical terms, the accreditation process may h point out the actions these institutions should undertake how best they can be implemented. Too few countries us formal accreditation systems, and only a small proportion periodic evaluation or inspection.[82] As the need for proper accreditation may quickly gain momentum worldwide, it is urgent to examine how accreditation mechanisms with an inbuilt social accountability component can be designed an adapted to different contexts.

Global standards

The debate over the appropriateness of applying internationa standards to assess the education of health professionals, particularly in medical schools, is not new. With globalization and the rapid exchange of ideas, information and experts and the emergence of international or continental trade agreements, this debate takes on more strength.

First, we should distinguish the goal of establishing standards of universal value from the establishment of international standards. There is no point in advocating a worldwide uniform medical school model that would disregard the specific features of the local cultural, epidemiological and socioeconomic contexts.

A global consensus is desirable and possible, however, on the essential features of a medical school, on essential functions of physicians to be trained and on essential principles and methods in education, research and service activities that any medical school should promote and apply. Also, minimal sets of standards derived from these essential elements as well as mechanisms for assessing to what extent these standards are met should be recognised as being of universal value.[92,93] In contrast, the term "international standards" may give the false impression that a supranational body is awarding a label of quality regardless of national specificities and requirements, and should therefore be used with caution.[83]

Regarding the assessment of social accountability, there are some basic common elements that may qualify for inclusion in a universal package. An example of such a

ckage is given in Fig. 14. It is composed of a series of steps at would apply to any educational institution. Nevertheless, e specific content of each step is to be described either by ie institution itself or by a national body responsible for egulating the quality of educational institutions and ensuring elevance to the local context.[79]

Collaborative research and development should be enhanced, including at the international level, to further elaborate on each step, develop procedural guidelines to implement each step and design and validate measurement instruments. The aim is to enrich a universal package for assessing social accountability that a variety of stakeholders in the health system, health service organizations, health settings and health professions alike may wish to adapt and use to better respond to society's needs and adhere to the philosophy of unity for health.

Educational programmes

Education can be defined as the art and science for preparing people to function properly in society.[89] The key word is "properly," therefore the definition should also include action to ensure that future graduates can exercise the skills they have acquired, or, in other words, that their future working environment will recognize most of their skills as relevant, applicable and desirable. An educational programme can be defined as an organized set of opportunities offered to learners so that they can acquire the capacity to successfully carry out a task, a function or a profession.

The notion of education can be equated to expectation. Learners expect to become experts, or knowledgeable in certain areas; teachers expect each learner to acquire predefined competences within the current educational framework and facilities; education policy makers expect to provide the required number of qualified graduates to society; new graduates expect due recognition of their titles and a job that meets their expectations; and society expects educational institutions to meet its needs.

In setting up an educational programme for health professionals we should be aware of these expectations. We will hope that each will be consistent with the ultimate goal of the programme, which should be to improve people's health by adhering to values such as those promoted by the TUFH approach, i.e. quality, equity, relevance and cost-effectiveness.

We submit that planning an educational programme is a political act, as it requires a sharp grasp of how it may contribute to society's well-being by influencing behaviours.[140] For this to happen, however, a sequence of actions is required beyond the usual teaching and learning activities. Figure 15

1. DECIDE on REFERENCE POINTS
   Reference points must be consistent with health goals, against which the performance of the institution will be assessed. Values of quality, equity, relevance and cost-effectiveness in health care or the equivalent should be retained as reference points.

2. CONSIDER DOMAINS of EDUCATION, RESEARCH and SERVICE
   Social accountability is to be judged in each domain and consistency is to be sought among the three domains.

3. DEVELOP BASIC INDICATORS
   Evidence must be provided on the level of attainment of social accountability in education, research and service for each of the reference points.

4. EMPHASIZE IMPACT
   Privileged attention should be paid to the impact on health care delivery and health status as results of socially accountable education, research and service. To the extent possible, indicators and criteria must be developed for an objective appraisal.

5. CREATE MEANINGFUL PARTNERSHIPS
   When and as required, cooperative links must be established between educational or academic institutions, health services, health professionals and communities to create synergies and improve effectiveness of action on priority health concerns.

6. ACCEPT EXTERNAL EVALUATION
   Internal evaluation must be followed by an external evaluation that also involves representatives of health services, the health professions and the society at large.

7. USE EVALUATION FOR INSTITUTIONAL DEVELOPMENT
   The assessment of social accountability should be part of the overall evaluation of the educational institution and used for accreditation. Results should be used for introducing sustainable institutional changes.

Figure 14. An example of a universal package for assessing social accountability

illustrates naïve linear reasoning whereby education by itself is seen as a powerful means of change: good education would lead to good graduates, which would in turn lead to good practitioners, to good health care and to good health status. Experience largely demonstrates that while education is an important determinant of practice behaviours, we must be aware of other factors playing more influential roles over which current educational systems have no or little control.

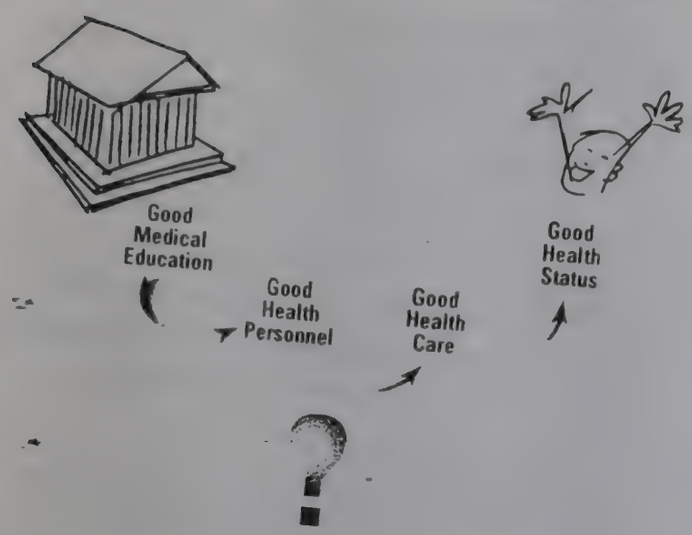

Figure 15. Education is only part of the solution

For instance, financial incentives or attractive working conditions may overshadow the influence of education in terms of career choice and adherence to certain practice patterns. In several countries, the existence of good university educational programmes in family practice has not drawn young doctors to the discipline to the extent expected, until they were attracted by better pay or improved status. The influx of family physicians to managed-care organizations in the United States of America supports this view.

In many instances, enthusiastic activists in health professions education are still beguiled by the possibility of a cascade effect or chain of causations that would be initiated by changes in educational programmes and lead uninterruptedly to improved health status. WHO, through its intensive teacher-training programme, may have encouraged this belief, even if not explicitly.[98]

Be aware of illusions

Too often and for too long, health programme managers have seen educational interventions as convenient means to make steady progress towards their objectives, without giving due consideration to the spectrum of conditions that ensure educational impact, particularly for sustainable changes in practitioners' behaviours once immersed in their day-to-day work.

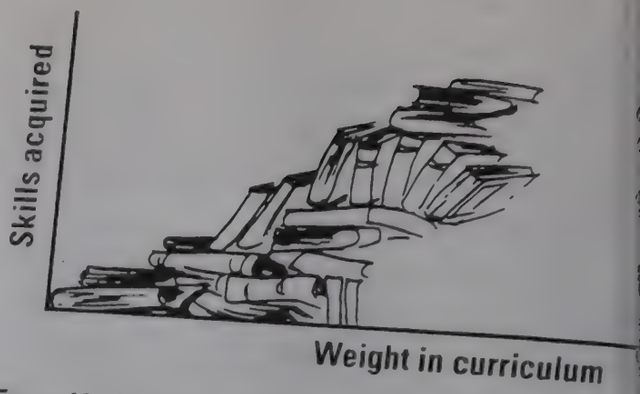

Figure 16. Educational Illusions (1)

Figures 16 and 17 illustrate two common kinds of illusion that may blur the sight of those who overestimate the power of education. In the first case (Fig. 16), the illusion consists of inferring a proportional relationship between what is taught and what is learnt, often ignoring the fact that securing optimal learning processes, particularly in the context of the future working environment of the graduates, is more important than the sheer volume of curriculum time for lectures. Early and longitudinal exposure to patient, family and community health problems and the use of problem-based learning approaches should be privileged.

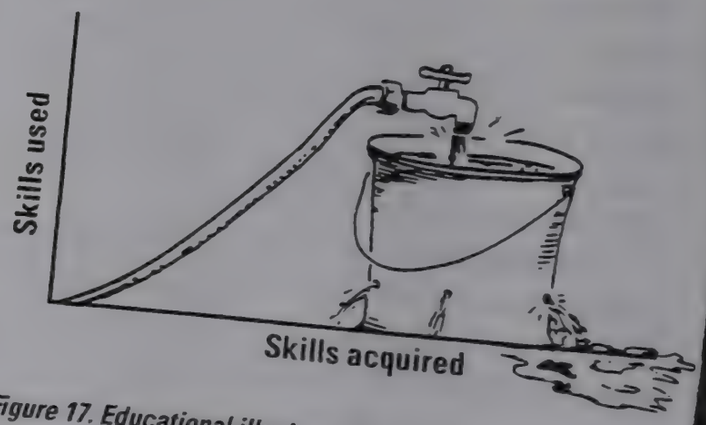

Figure 17. Educational illusions (2)

In the second case (Fig. 17), the illusion consists of assuming that what is learnt will necessarily be practised, a situation already referred to earlier when educational initiatives, no matter how good they may be from an educational-methodology point of view, are not accompanied by incentives for the health professions. In a typical example, educational institutions energetically engage in a fundamental reorientation of their educational programme towards issues such as primary health care, a balance between preventive and curative services, population health perspectives, multidisciplinary action and teamwork.[99]

Unless concomitant changes take place in the health system, new graduates do not find job opportunities consistent with the noble principles and methods to which they have been exposed. The mismatch between education and

practice is a profound source of disappointment, which erodes the potential of innovation in many educational institutions.[8] The emergence of the TUFH project has been largely stimulated by the experience – now widely documented – that educational reforms by themselves do not induce reforms in professional practice, or in other words, that the delivery of a new breed of health professionals by well-meaning educational institutions does not lead to the creation of job opportunities unless this is planned by the health system.

An important rationale of the TUFH project is to foster consistency between education and practice. In facilitating the integration of medicine and public health and the convergence of different stakeholders' inputs, the TUFH project provides a solid base for educational programmes shaped to meet the health needs of both individuals and populations and to prepare health professionals appropriately. Important educational programmes, such as creation of a new category of health profession or reorientation of existing basic educational programmes for new professional profiles, should be developed from the perspective of coordinated changes in education, practice, and health care delivery systems.[6]

In promoting family medicine, for instance, we may envision a coordination of the following: the development of a governmental policy to recognize family medicine as a foundation for health service organization; the provision of professional and material incentives to practise as family physicians; and the development by academic institutions of research and education in order to promote family medicine as a respected discipline.[9]

Figure 18 shows the interrelationship between the three components. The diagram can be interpreted differently. If the TUFH approach were a common reference to optimally respond to people's health needs, we would advocate that patterns of health care should

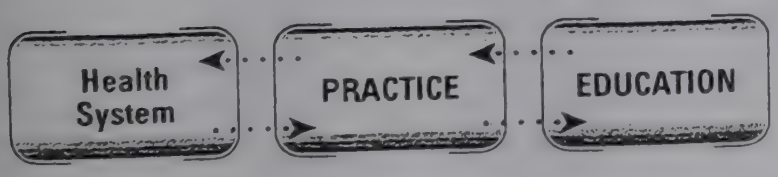

Figure 18. Mutual influences between health systems, practice and education

determine the kinds and numbers of practitioners that educational programmes should prepare. Conversely, educational programmes and institutions can be proactive and contribute towards designing innovative patterns of health care and preparing the ground for the future graduates by imparting the skills needed.

In planning and developing educational programmes, we should do everything possible to ensure that they influence practice behaviours and make an impact on health status. This requires education policy makers and leaders to consistently coordinate their work with those responsible for planning and implementing health services.

Figure 19 suggests three scenarios illustrating various levels of interaction between schools (or educational programmes) and health services in search of an optimal match in expectations from both sides.

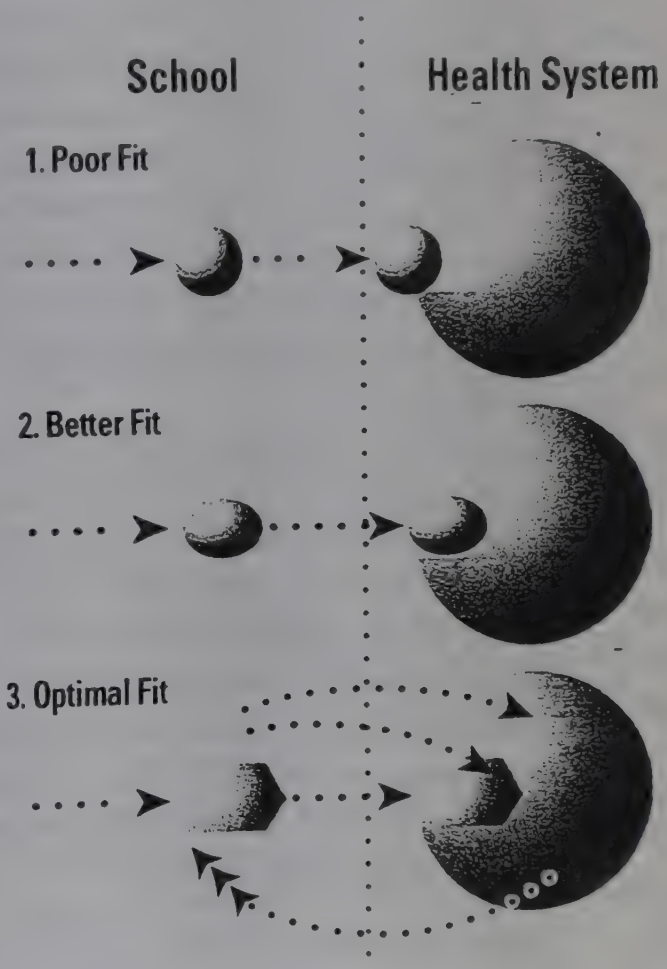

Figure 19. Seeking an optimal fit

Situation 1 depicts a *poor fit*, in which an educational programme produces personnel who fulfil only a small part of what a health service expects. Educational programmes have been designed with minimal consultation with prospective employers. Job profiles are rudimentarily sketched – if at all – with the assumption that the proposed mix of skills is appropriate. This situation is prevalent when curricula are borrowed from foreign contexts or where they are not periodically

reviewed for relevance.

Situation 2 depicts a *better fit*. It occurs when educational programmes are tailored to the needs of services. Here health service managers and health professions educators have agreed beforehand on the configuration of the educational programme. Learners are given ample opportunities throughout their education to be acquainted with service requirements, and learning sites reflect the working environment.[94,95,96,97,98]

Situation 3 depicts the *optimal fit*. Here educational institutions and health services share a common concern to reshape the health services delivery system to better meet people's health needs. Proactive educational institutions are critical of the future job opportunities offered to their graduates. They are eager and able to work jointly with health services and representatives of health professions to design new practice patterns more suitable to respond to needs of individuals and populations, which determine in turn the core competences future graduates must acquire. In this scenario, both the structure of the service and the profile of the health profession have been changed under reciprocal influences. This should apply in the ideal case of a TUFH project as coordinated institutional reforms are made in education and practice.

This points out the desirable mindset of initiators and managers of educational programmes as they seek to make an impact. It also suggests that quality in education should have a double and inseparable focus on process and outcome. Quality assessment and accreditation in education should gauge not only how relevant and efficient the educational processes are but also how an educational initiative is able to induce or participate in changing the practice environment so that graduates can fully apply their acquired competences.

Education as a popular entry point

Investing in health professions education remains popular, and agents of health system change should use this opportunity to stimulate major reorientation in practice patterns, taking into account the cautionary remarks made earlier. Governments and institutions alike widely consider educational investments indispensable in most health programmes.

Education is the most visible element within the scope of human resources development functions. It can be seen as the core function around which other functions such as workforce planning (e.g. relevance of the *numerus clausus* to the medical school) or workforce use (e.g. tracking of graduates to analyse career choices) usually revolve. Planning may be seen as "upstream" from education, and used as "downstream" from it. The metaphor of the "hamburger," where education would be the "meat" and the other functions the "bun," would apply in this case.[93]

The importance given to education as an investment is also due to its being a self-contained domain of work, requiring a policy, an infrastructure, technical and material resources and leading to palpable products, namely the workforce required to staff health services. The concept of education and educational programmes should go beyond the conventional teaching and learning of sets of disciplines to mean a strategic opportunity to stimulate health development by finding and promoting an optimal match between the workforce produced and the services to be delivered.

However, such a system-wide approach is not the rule, as many promoters of individual educational packages fail to realize the difficulty of making the system as a whole accommodate their specific wishes. This occurs, for instance, when an educational module on a given subject is introduced to an already-overloaded curriculum, with little understanding of strategies and protocols for making sustainable changes in educational programmes and institutions.[91]

PRINCIPAL PARTNERS

The challenge of setting up a sustainable health service delivery system based on people's needs, as advocated by the TUFH approach, calls for the active contribution of key stakeholders, or health partners. Although not an exhaustive list, five principal partners have been identified: policy makers, health managers, health professionals, academic institutions and communities. All have their own features and references, strengths and constraints, expectations and agendas.

However, this heterogeneity can be mitigated if they share a common set of values such as quality, equity, relevance and cost-effectiveness, as well as a certain vision for the future health service delivery, such as one founded on TUFH principles. "The partnership pentagon" (Fig. 20) illustrates the richness of possible permutations in establishing working relationships among partners with the common aim of creating a health service based on people's needs.

PENTAGON PARTNERSHIP

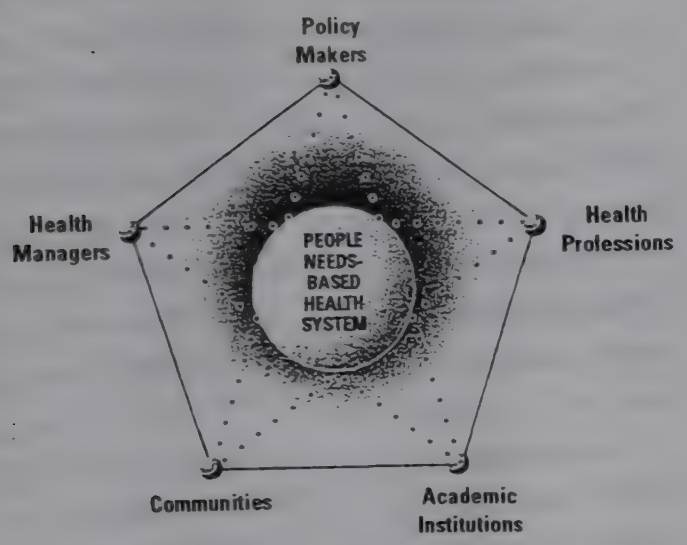

Figure 20. The partnership pentagon

A productive and mutually rewarding partnership can be contemplated if the stakes for creating unity for health are well known and documented. Partners or stakeholders must be aware of their individual potential and the added value of partnerships.[100,102] Each should accept that shared interests should prevail over sectoral interests.

Policy makers (9)

Policy definition and enforcement are indispensable for a sustainable reorientation of currently fragmented health service delivery towards a coherent and unified approach. The government must state its commitment and support for the approach, and possibly reinforce these by legislation. Authorities at central or decentralized level may then decide to allocate resources for locally designed initiatives that comply with the TUFH principles, for instance.

Politicians, concerned with maintaining cost-effective health systems and aware of people's increasing demands for quality and equitable services, generally adhere in principle to innovative approaches for creating unity in the health system, as they offer better responses to people's needs. However, they should use their power base to facilitate transforming the health care delivery system to adhere to the values of quality, equity, relevance and cost-effectiveness by supporting initiatives that may contribute to that end. Rhetoric should be matched by practice.

In the government, they should help shape a common vision for a health system based on people's needs among the different key stakeholders and facilitate partnerships. Officials in the Ministry of Health should initiate a consultation with their colleagues from other ministries on the implications that such a system would have for higher education, labour, finance, civil service and elsewhere so as to create an environment conducive to implementing desired changes at the operational level. To be brought into effect, exhortations for change must be accompanied by encouraging measures, both regulatory, such as rules and guidelines, as well as remunerative, such as offers of new and attractive working opportunities and incentives.[103,104,133]

Local government representatives at provincial or district levels, for instance, can play a significant role in supporting locally generated innovative patterns of health services delivery for eventual dissemination and reproduction on a national scale.

In the private domain as well, policies can be reviewed to ensure an optimal contribution of the health industry, health professional associations and academic institutions to more socially accountable health systems. The motivation for policy reformulation would lie in the understanding of far-reaching implications of health system changes for the private sector and the wish to be associated with these changes at the very onset.

▼

Looking for policy support

In country X, models of a population-based health service were successfully implemented as a joint undertaking between the local health centres and the department of community medicine at the university.

The health of a population of 50,000 inhabitants was regularly monitored and programmes were delivered with a view to ensuring universal coverage with essential health service packages.

Health professionals of different categories as well as community-initiated projects actively participated in the programme. A steering committee composed of the principal actors met regularly to decide on priorities, assess progress in programme delivery and allocate resources.

Against all odds, the programme was discontinued when after five years of successful work and evidence of impact on people's health, the two principal charismatic leaders of the project were transferred to other positions outside the area.

The project failed to obtain more than oral interest from government officials in this outstanding endeavour to engage forces from different contributors, which warranted continuity and institutionalization of a partnership through adequate policy and funding support.

▲

Health managers

The term "health managers" should be understood to mean those responsible for organizing and financing health services, such as for instance in health care institutions or health insurance plans. To what extent do they and can they contribute to creating unity in health care? Under what conditions can they be won over to the cause of unity?

Health managers are accountable for fulfilling the mandate of their health institutions, which vary considerably in scope, from a tertiary hospital to a primary health care setting. A primary health care setting, for instance, can more easily make the necessary adjustments to adhere to most of the criteria to create unity in health services, with a general population as a target. A specialized health care institution, essentially designed to focus on specific health risks or diseases and for target groups within the general population, is less prone to reducing the fragmentation in the health service.

Reference hospitals and community hospitals may have designated catchment areas but are usually not designed to coordinate health actions for an entire population.[105] "Health promoting" hospitals, however, are run with the intention of becoming socially accountable, as they endeavour to address broader health issues affecting the population, beyond the presenting cases and follow-up of patients and their families.[53] Such hospitals widen the scope of their mission beyond institutionalized care and are actively involved in community-wide health programmes. In some cases, they may bear a significant burden of basic health services to the poor, the disadvantaged and those not well covered by a health insurance scheme, through partnership with local government, academic institutions and the community.[54]

Health maintenance organizations (HMOs) are institutions designed to address a wide array of health concerns of their enrollees. Depending on the nature of the contract, enrollees are provided with a range of preventive, curative and promotive services to minimize health risks and problems. The enrollees form a population whose epidemiological data are analysed and used for service planning to their benefit. This demonstrates coordination between individual health and population-based health services, although restricted to enrollees.[106]

Segments of society without health services, inadequate referral mechanisms among different levels of health services and lack of a productive working relationship between government or private institutions with a view towards establishing comprehensive health services for the general population are notable. The principle of patients lists implies that every individual is registered with a general practitioner/family physician. General practice and primary care teams propose that such a mechanism can eventually cover the entire population with a web of essential services and allow coherence and integration among individual and population-based health functions in a given territory.

In rare countries where essentially the entire spectrum of primary health care services is provided by a network of publicly controlled and funded health centres or polyclinics, there is in principle a good chance to create the desired unity. However, the competition needed to stimulate creativity and performance and the inevitable emergence of private entrepreneurship threaten the solidity of such an arrangement; innovative compromises and rearrangements are called for.

Which will ultimately prevail, the social agenda or the vested interests?

In the event that a social agenda such as that embodied in "Towards Unity for Health" eventually prevails and becomes attractive to health institutions and health managers of both the public and private sectors, it will induce streamlining of constraints and opportunities and strategic repositioning on the health chessboard, as well as changed roles for health professionals.[107]

professionals

rofessionals should be duly recognized as important
s in sustainably reshaping the health care delivery
. Health professionals are the doers, the working arm
system and those upon whom the successful imple-
ation of any health programme ultimately rests. Not only
ld their endorsement for any reform project be sought,
heir early consultation and creative contribution should
onsidered indispensable.[108] While primary health care
viders play an obvious role in orienting health services
vards priority health needs, the cooperation of specialists
also essential to strike a balance between technology
evelopment and cost-effectiveness in health care.[109,110,111]

Health professions are made up of a number of catego-
ies characterized by a core of specific skills, rules, habits
and expectations, which may vary from country to country.
Their influence, through their numbers and qualitative
interventions in policy determination, also varies with the
national context. In some countries, professional associa-
tions are well organized and politically important; in others
they barely exist.

Because health professionals are motivated by different
dynamics than educational institutions that train them and
provide them with role models, or health care institutions that
employ them, they should be intimately involved in any important
health system changes. For instance, private practitioners may
express reservations regarding policies calling for geographical
distribution or rescaling their fees. They may be supporters or
opponents of "Towards Unity for Health," depending on whether
their views and expectations have been properly taken into
account.

Too seldom have health professionals as a group
spearheaded important reforms in the health or social sector
with quality, equity, relevance and cost-effectiveness as
reference values. Too often have they projected – rightly or
wrongly – an image of turf protectors, defending their own
interests instead of the interests of the individuals and
communities they are meant to serve. Generally they play
little part in health system changes. However, they can take
up the challenge for moving from defensiveness to
proactiveness, as they have the potential to lead the process
of change if they are able and willing to make some important
readjustments.[9,112]

Among other challenges, they should find a proper
balance between the promotion of their discipline and
society's needs. The health professions should minimize the
negative effects of competition among themselves for
survival or expansion. They should maximize their strengths
by promoting ethical values in the health sector and being
advocates of the poor and the disadvantaged. They can
highlight the necessity of using problems and issues affecting
the daily life of patients and families as basic references to
reorient the health service delivery system and harness
partnership between other key stakeholders, namely health
care institutions, academic institutions and communities.

In view of their privileged and critical position on the
health chessboard, the health professions should review how
they can optimally respond to the pressing issues in the
health system and collectively adopt a more coordinated and
integrated approach for health services centred on people's
needs, a movement of which they could be at the forefront.
Taking an oath to fulfil such a social contract would be of a
great symbolic significance.

Academic institutions

Because of their wide spectrum of functions in education,
research and service delivery in a variety of disciplines,
academic institutions have the potential to understand and
address complex issues with a systems approach and
therefore to create synergies among different groups. The
capacity and responsibility of universities in promoting
holistic human and social development is recognized
worldwide.[88] No other institution, besides a government
cabinet, has better opportunities and skills to manage an
intersectoral project than a university.[113] The World Health
Assembly also recognized the special role that universities
can play in implementing health strategies, such as the
"Health for All" strategy, which requires interventions of a
political, social, cultural and economic nature in addition to
specific health interventions.[114]

Paradoxically, universities face the criticism of being
"ivory towers": arrogant, ready to teach but not to listen and
learn, and therefore not responding optimally to society's
needs. While they may be regarded as centres of excellence
and references for practitioners and society in general, we
may criticize their lack of proactive contributions to social
change and complain of their relative isolation.[84] It is fair,
however, to appraise instances of fruitful working relation-
ships between health sciences faculties, health services and
communities. Also, the movement towards enhancing
medical schools' responsiveness and accountability and
linking with other stakeholders in improving people's health
status is worthwhile noting.[87,115,116,117,118]

In fulfilling their educational mission, academic institu-
tions are at the crossroads of strategies for changing the
mindset of health partners. They can set standards to which a
host of institutions and organizations can adhere. They can
articulate the profile of health professionals needed and set

models for practice patterns. By keeping track of their graduates' capacity to meet the principal health concerns of individuals and populations, they can provide the evidence that may influence the practice environment.[119]

All in all, academic institutions, and educational institutions in general, still enjoy high visibility in society; they are seen as instrumental in preparing future generations of cadres and workforce. Because education is generally viewed as a public good and therefore as a sensitive political issue, institutions bearing the prime responsibility for its delivery should benefit from privileged attention.

Academic institutions can play a privileged role in the TUFH project if they are able to make the best use of their exceptional potential. They have demonstrated their capacity to be the engine of collaborative action with other partners and a cement in the interface between health care, professional practice and education.[7] By carrying out health systems research, they can design and test innovative patterns for integrating medicine and public health and creating convergence of different stakeholders' inputs, and therefore exercise leadership in launching a TUFH project. The unique combination of strengths imbedded in their staff, students, and their network of affiliated bodies, through their education, research, service delivery and policy definition functions, should embolden them to take the lead in such an initiative.

Communities

Individuals or groups, either as users and health service beneficiaries or as contributors to health programmes, are increasingly seen as important partners. The combination of increased awareness of health issues through education and information and the fact that people's voices are being better heard, has led the average citizen to better understand and cope with health risks and opportunities and become a part of the decision-making process in health service delivery.

In industrialized countries and increasingly in developing countries, the major cause of ill health and consultations to health services is unhealthy lifestyles and risk-taking behaviours with respect to nutrition; safety at work or on the road; sexual activity; tobacco, drug and alcohol consumption; lack of physical exercise; and quality of interpersonal relationships. All are domains for which the major responsibility lies with each individual. People can and should participate more in the protection or restoration of their own health by adopting behaviours directly or indirectly conducive to the enjoyment of physical, mental and social well-being.[120]

At home, in the workplace and during le
individuals and communities can play a deter
health promotion. Voluntary action in any hea
programme should be enhanced. Through rep
on local health councils or on the boards of ed
institutions, the community can influence polic
nation and priority-setting.[121]

Individuals and families are health actors w
obtain proper health information and are able to
best use of it for independent decisions regarding
health. When computer technology is part of daily
immediate access to one's individual health record
via a "smart" card) and interaction at a distance w
host of health resources through telecommunicatio
technology should afford a unique opportunity to ind
als to assess their health status or exposure to risk a
decide on period checks or preventive measures.[122,123]

While the principle of responsibility cannot be
dissociated from the principle of empowerment, we sh
be aware that many people in many countries may not
able to assume responsibility to the desirable extent, du
to their socioeconomic situation.[124,125]

In health professions education, communities can
also be appreciated in different circumstances. For
instance, they offer themselves as learning sites for healt
sciences students, giving them an opportunity for early
and continuous exposure in their curricula to real-life
situations and health issues. In such cases, they offer
occasions to students to practise problem-solving and
demonstrate a capacity to come to grips with reality. By
their assessment on how their needs are met, they also
help educational institutions to reorient their educational
programmes. Individuals can also participate directly in
educational programmes, as genuine patients or by role
playing. Here again they should not be passive, as their
appraisal is most valuable to help protect and promote
critical values in the patient-provider relationship, such as
respect, empathy, patience, personalized care, compre-
hensiveness and empowerment.

More than ever, particularly in the face of the over-
whelming role of biomedical technologies, the human
dimension and ethical issues should be enhanced in
health services planning and delivery. The four other
health partners – policy makers, health managers, health
professionals and academic institutions – should privilege
a community-oriented or people-centred approach in their
work, therefore consulting communities more often for
guidance. In return, representatives of communities
should adequately reflect needs of all constituting groups,

particularly those most vulnerable: the lonely, handicapped, homeless, jobless, elderly, discriminated-against and disadvantaged of all kinds.

BUILDING PARTNERSHIPS

Unity can result not only from integration of important sets of activities, such as those related to individual and population-based health services, but also from the active involvement of key stakeholders in partnerships to establish and support such a system. The unity is created on the double front of actions and actors. "Created" is indeed the word, as the phenomenon of unity will not happen by chance, but can result only from a will and a purposeful strategy.

While promoters of unity for health may have a fairly good knowledge of the repertoire of key health actions to be linked, as well as the specific strengths and weaknesses of each stakeholder and actor, the magic recipe to ensure a productive and sustainable partnership still remains to be found. We do not create mayonnaise just by pouring eggs, oil, vinegar, salt and pepper into a bowl together. Special skill is needed in mixing and a certain chemistry must be activated. Similarly, to produce the added value of working in partnership is probably one of the most challenging tasks for health reformers and is a subject for research and development on its own.

Figure 21 shows that a strong partnership is needed in the development of a TUFH project.

The "partnership pentagon" features a web of possible relationships among partners, each partner teaming up with all the others (see Fig. 20). Although this configuration is theoretical, it allows us to visualize opportunities for partnership.

To creatively contribute to the establishment of services based on people's needs requires each partner to give up some prerogatives that may contradict the purpose of the TUFH project. However, partners or stakeholders may surrender some of their power in creating alliances for unity in health not entirely for altruistic reasons, as they realize that new opportunities should emerge for conservation or expansion of their status and privileges. They should praise the added value created by synergistic collaboration.

For a better appreciation of the value of synergy created through partnership and as guidance for TUFH project planners, it is useful to review some of the facilitating and restraining factors for a collaborative process, as controlled by each of the five partners/stakeholders (see Table 6).

In sorting out the pros and cons of establishing a partnership with some stakeholders, we should seek to obtain complementarity, enhancement of strengths and neutralization of weaknesses. In a given socioeconomic context, we should be able to decide which alliances to privilege in the first instance and at what pace to expand the partnership to a wider number of stakeholders.

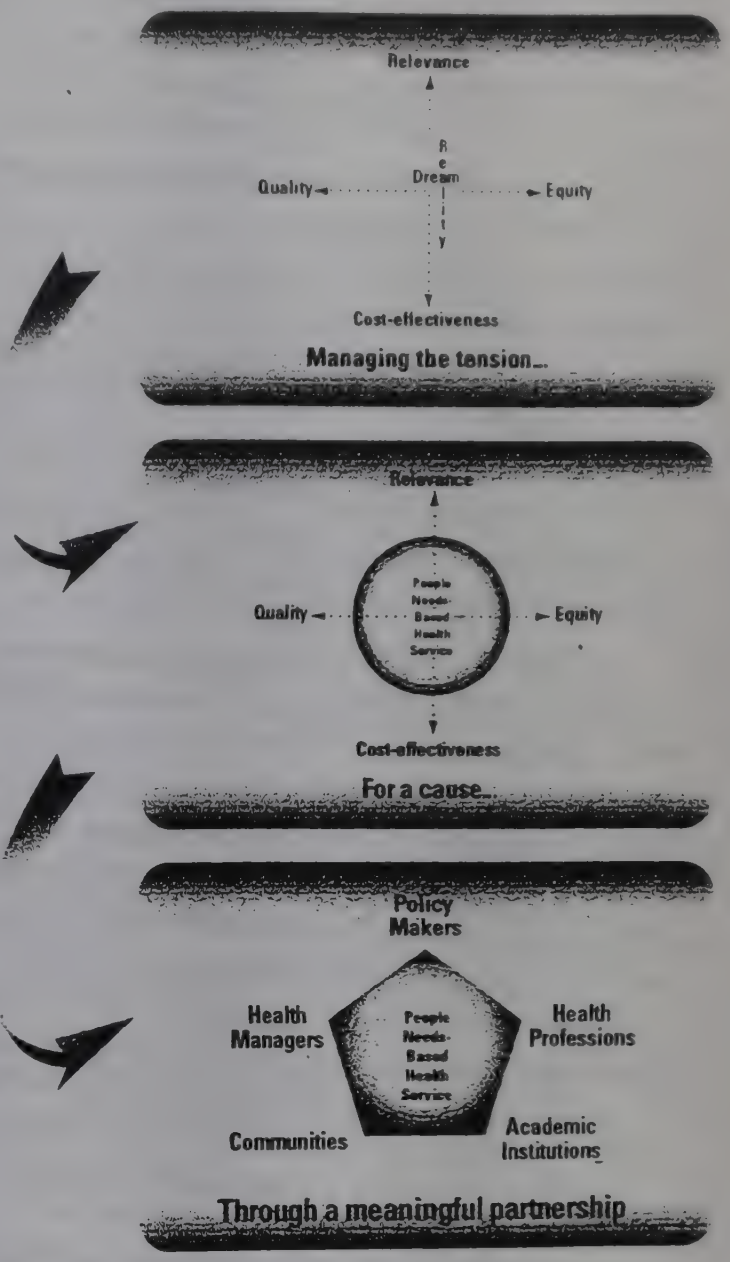

Figure 21. Meaningful partnership for a TUFH project

Lessons can be learnt from experiences of partnerships involving different stakeholders. If in the "partnership pentagon"(Fig. 22) (1) stands for policy makers, (2) for health managers, (3) for health professionals, (4) for academic institutions and (5) for communities, we may refer to the following combinations.

(4)–(5)

This is probably one of the best known if not most attractive partnerships, linking academic institutions and communities. The quest to make the education of health professionals more relevant to the needs of those to be served has led academic institutions to interact with the community. While

	Facilitating factors	Restraining factors
Policy-makers	• Capacity to articulate a long-term vision of a health service delivery system. • Potential to highlight on priority health concerns and people's needs in an unbiased way and provide evidence for it. • Capacity to set conditions for resources allocation by regulatory mechanisms and legal action.	• Risk of being politically biased and not neutral enough to equally inspire trust among some stakeholders to get involved in partnership ventures. • Difficulty in translating policy orientation into a range of organizational models conducive to synergistic action. • Lack of consistency and continuity in advocacy and support for institutional changes by failing to monitor an evaluate progress.
Health managers	• Potential to add credibility to partnership projects by a critical appraisal of their economic feasibility. • Capacity to stress on concrete implications for the (re)allocation of responsibilities among parties. • Provision of resources to support collaborative work if evidence of benefits is given.	• Tendency to focus on specific subgroups (i.e. enrollees in health plans, patients, people at high risk) rather than a general population. • Risk of restricting attention to vertical rather than horizontal and intersectoral approaches in solving health problems. • Inclination to be self-sufficient in fulfilling the mandate by essentially referring to economic and administrative criteria.
Health professionals	• Direct and constant contact with people as principal providers of health services and compliance with a code of ethics in service delivery. • Concrete implementation of policy-decisions and operational procedures with capacity to provide on-going feedback. • Permanent source of information regarding health concerns and priorities of individuals and society at large.	• Organized in strong associations to protect sets of values and corporate interests. • Autonomous minds and scepticism regarding usefulness of wide partnership except with their like-minded service providers. • Competition among the health professions, sometimes at the expense of equity and cost effectiveness in health services.
Academic institutions	• Capacity to induce the acquisition of desired skills and behaviours for the implementation of a health agenda. • Inquiring mind and application of research methodologies to design and assess innovative models of health service delivery. • Role model for practitioners and reference regarding quality of care and health technology advancement.	• Relative isolation from the social context leading to misalignment of education and research programmes with priority concern and evolution of health systems. • Sanctuary of specialities and subspecialties the expense of a holistic vision, largely responsible for fragmentation in health car • Lack of leadership for practical guidance implementing multidisciplinary approaches health and social development.
Communities	• Expression of needs and expectations with a problem-oriented approach. • Increasing awareness of rights and obligations, as well as opportunities for influencing the health agenda. • Voluntary force, readily available for collaboration and easily mobilized for altruistic causes.	• Tendency to excessive demands and relat reluctance to share risks and responsibili • Volatile and unstable partnership, particu for long-term action and institutional cha • Influence by media and fashion. Passion moment sometimes prevails over rationalit facts.

Table 6. Facilitating and restraining partnership from five stakeholders

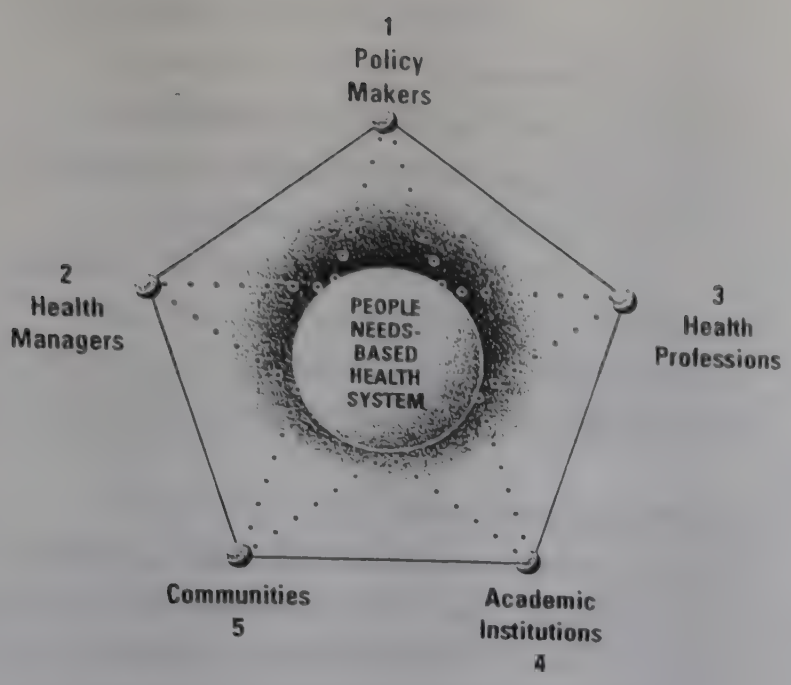

Figure 22. Examples of partnership

curricula are tailored to reflect the local epidemiology and to respond to people's needs and expectations in a given context, faculty and students are put in contact throughout the educational process with communities – listening to them, learning from them, working with them, helping them.[137]

In return, community leaders and representatives advise educational institutions on student admission, selection of learning sites and identification of special areas for research and service attention. The case of Zamboanga Medical School (southern province of Mindanao, in the Philippines) illustrates intense consultation with the local communities in establishing the institution.[134] Several national and international networks of community-oriented educational institutions have been operating for years, some with the support of WHO.[115]

(2)–(4)

This demonstrates a wish to harmonize health services and health workforce development. Under the banner of primary health care, WHO has long recommended that planning, training and deployment of the workforce be an integral part of health services development, to ensure consistency in purpose and optimal match between health needs and human resources.[126,127]

In this context in some countries, mechanisms for joint responsibility for health services and medical education have been established.[128,131,147] In several instances the training of health workers (nurses, midwives and allied personnel) has been provided by health service organizations. Recently some countries have raised the possibility of incorporating health professions schools into large consortia of health care institutions, with a view to producing a workforce to cater for specific needs.

(2)–(4)–(5)

This triangular relationship illustrates the concern for a coordinated approach of academic institutions, health services and communities in health programmes. The UNI programme supported by the W.K. Kellogg Foundation is a vivid example of such a collaborative effort, with universities being prime movers.[118] In the case of "health-promoting hospitals," a hospital initiates the process of establishing links with communities and academic institutions to take a holistic rather than disease-focused approach to health and reach out to patients and families in the community, particularly to the disadvantaged.[53] Few academic teaching hospitals display an enviable record in combatting inequities in health through networking.[54]

(3)–(4)

This type of partnership can be expressed in several ways. The university as the *alma mater* entertains privileged partnerships with professional associations. This can be demonstrated by continuing-education or research programmes that receive equal inputs from both sides.[138] Health professionals working in the community are granted teaching appointments by universities, and students are placed in a field practice setting under their supervision, to the satisfaction of both.[139] Leaders in medical education and medical practice often join skills to shape guidelines for best practice or standards for quality in education. The Liaison Committee of Medical Education is a North American illustration of collaboration between medical associations and medical colleges in the accreditation of medical schools.[129]

(1)–(2)

This relationship can be illustrated by the mutual support sought by public health departments, run by governmental health authorities, and health care organizations, such as managed-care organizations. Such a relationship is founded on the premise that collaboration between medicine and public health is in the interest of both partners and best serves the public's interest.[130]

(1)–(2)–(4)

What may seem an elitist relationship between policy makers and academia may have interesting outcomes. Instances exist in which primary health care-oriented policies have found their best support among academic or educational institutions, particularly when sponsored by the government. The influence of academic leaders on health policy shaping is

not negligible, as is shown by the number of deans of medical schools who become ministers of health in some parts of the world. Primary care and the role of general practitioners or family physicians can be emphasized by the "government/universities" pair in subsidizing the creation of departments of family medicine in medical schools, while health managers and their employment policies can facilitate job opportunities.

(1)–(4)–(5)

The correction of maldistribution of the health workforce can be approached by this relationship. The redistribution of physicians towards underserved rural areas can result from the convergence of health policies, targeted medical educational programmes and support from the host community through the provision of adequate material and social rewards to prospective settlers.

(1)–(2)–(3)–(4)–(5)

To our knowledge there are few instances of full-fledged partnership, which requires a high degree of coordination. On a national scale, a health system may favour such a partnership.

In the United Kingdom, for instance, the National Health Service – with clearly defined health policies and objectives – calls upon the health professions, namely general practitioners and primary care teams, to assume gatekeeper functions (or "opportunity opener" functions) for access to more specialized services and broader managerial responsibilities in the health system, with some participation by academic institutions and communities.[135]

In Australia, divisions of medicine are decentralized endeavours, encouraged by the federal government, to facilitate collaboration among different general-practice settings to address in a coordinated fashion a wide spectrum of services for certain groups of patients with chronic conditions who live in defined areas. Multidisciplinary approaches are used, while comprehensive and continuous care, as well as appropriate referral mechanisms, are basic commitments. Consumer groups participate in the collaborative process to both ensure relevance of services to their needs and enhance their participation.[136]

The above is just a sample of possible partnerships. Some arrangements are appropriate to address a given set of problems, while others address different sets of problems. Obviously, in each context an optimal relationship with partners must be worked out.

A word of caution!

The value of partnership depends on the level of commitment of each partner. Contact between stakeholders is not enough to guarantee productive partnerships.

Some cynical observers may depict the "partnership pentagon" as a bunch of crabs concerned mainly with protecting their own turf, lacking the systems view required to help create sustainable and socially responsive consortia.

Another word of caution!

Can the pentagon become a hexagon? Yes, the partnership can be enlarged to include other parties directly or indirectly involved in health-related activities with economic, social, cultural and environmental determinants in health. But pragmatism should prevail in efforts to enlarge partnership.

It should be recalled that the approach advocated by the TUFH project focuses in the first instance on the partnership needed for health service delivery based on people's needs. In the quest to optimize service delivery and health promotion, TUFH advocates should collaborate with agencies or individuals from sectors as varied as education, agriculture, industry, nutrition, transportation, employment or environmental control as and when health-threatening or health-promoting events in these sectors are identified. Very often, these events can be dealt with through one of the partners of the "partnership pentagon," notably community representatives, for instance, for health protection and promotion in homes, schools and workplaces.

At a national scale, on one hand, governmental authorities should take into account the implications of economic and social policies on people's health. For example, the conditions for restructuring and revitalizing the national economy and the corollary privatization and decentralization, as well as the influence of globalization, require regulatory action and coordination at the highest level of government to minimize the threat of inequities, unemployment and poverty.

On the other hand, an approach such as the TUFH project, while considering the political and economic decisions taken on a macro scale, privileges a bottom-up approach, starting with a recognition of the priority health needs of a reference population and coordinating the use of resources and talents available at that level. As a bottom-up approach requires constant updating through research and development to adapt to people's needs, it deserves to be considered as a way to address the formulation of national health policies.

SUSTAINING PARTNERSHIPS

We can assess a partnership as it evolves, from very casual to institutionalized, taking into account the depth of commitment of all partners. Three levels can be distinguished.

Level 1. Ad hoc arrangements

This partnership arises either spontaneously or after minimal planning. Partners may agree to meet regularly and exchange information as they recognize areas of mutual interest.

The following are examples of this level of partnership: health care organizations and educational institutions may jointly plan field training exercises and agree on mutual inputs; health authorities, academic institutions, health professionals, health managers and communities may be represented on the health council of a city, district or province to exchange views on priority health issues and deliberate on the most appropriate ways to address them; hospital administrators and health professionals in the community may seek a *modus operandi* for optimal reference procedures.

These arrangements are not sealed by a formal agreement. Any partner may break away if a more advantageous opportunity arises. However, a level 1 partnership can evolve into a level 2 if all partners agree.

Level 2. A project

This is more binding, as different partners have formally agreed to invest in a common project. A contract is signed, stipulating common objectives and expected outcomes, as well as each partner's obligations. A budget, timeline and specifications for project management are formulated. The project is usually placed under the auspices of higher hierarchical levels, so that it may be replicated on a wider scale and lead to lasting institutional changes.

For example, in mounting a primary health care demonstration project, government health services, academic health centres and communities may enter into a partnership. In this case, community health surveys, epidemiological surveillance, services to the community, education and research activities are conducted collaboratively. The implementation of the project plan, which outlines the specific contributions of each partner over a number of years, receives financial support from some of the partners or from an external source of funds. Monitoring and evaluation is foreseen to assess progress in meeting the objectives and the feasibility for expansion and adaptation of the project to other areas in the nation.

Another example could be a consortium to fight a commonly identified priority health problem, such as AIDS, adolescent pregnancy or multiple sclerosis. A programme is set up with the active support of political and policy-making bodies, while contributions of other partners are delineated: health organizations target activities in favour of people at risk; health professionals participate through continuing education programmes and subsidies; educational institutions update their basic and post-basic educational programmes; and voluntary organizations in the community provide logistical and social support to needy individuals and families.

A project, by definition, is time limited. This means that during a limited period, important transformations must occur to durably improve the health services delivery system. Certain features should be taken into account in planning for a successful project. Stakeholders participate for tangible advantages, material or other, so when benefits become mitigated or funds dry up, the consortium becomes fragile and more permanent resources and support must be brought in. The long-term outcome of the project may also be jeopardized by the inactivity of one or more partners, if there are no formal means to force each partner to assume a fair share of responsibilities.

Many projects have failed to have lasting influence on the behaviours of stakeholders, in the absence of timely introduction of a strategy for long-lasting institutional change. A project can be judged successful when it results in a shift from a temporary to a permanent partnership (see level 3 below). The project time must be used to facilitate this shift.

Level 3. Long-term commitment

If stakeholders find the TUFH project sufficiently attractive to take part in it to reshape the health service delivery system, they must agree to give up some of their prerogatives, with the hope that such concessions can in the long run provide new opportunities to maintain or expand advantages. Giving up what is real to obtain the hypothetical requires that each stakeholder possess a long-term vision of the evolution of the health system and anticipate favourable and unfavourable events associated with this evolution.

A long-term commitment to create unity for health may require a stakeholder to review its mandate (or its *raison d'etre*). For instance, hospitals and academic institutions may have to embrace a new spectrum of activities related to community health and the promotion of equity in health. Likewise, health professionals may have to readjust their working habits, if teamwork and sharing decision-making become more prevalent. Health service organizations may

promote the role of primary care teams coordinated by general practitioners and family physicians.

The following are five personalities with different agendas:

- Mr. A is a local politician and a government-employed epidemiologist;
- Mr. B is director of a provincial public hospital;
- Mr. C is a family physician paid on a fee-for-service basis;
- Mr. D is a university biochemist, known for his bench research;
- Mrs. E is a volunteer in a community organization for home visits to the elderly.

Can a useful partnership be built among them? Which common values are they willing to share?

Let's examine their complementary strengths to negotiate an agreement.

Figure 23. The challenge of building sustainable partnership

Partnerships last if formally regulated. After research and negotiation have defined each stakeholder's primary and secondary responsibilities and areas for complementarity and acceptable overlap, legal and financial arrangements should be taken to formalize roles and patterns of work.

The notion of accountability to serve the cause of unity for health should be acknowledged and appropriate mechanisms put in place to assess each stakeholder's contribution. For alliances to last, the identity of each stakeholder must be preserved, but a balance must be struck between meeting commonly agreed-upon goals and specific interests. These must be able to evolve and adapt to emerging needs and expectations, guided on an ongoing basis by monitoring and evaluative research.

For health entrepreneurs, it is important to distinguish the three levels of quality in partnership described above and to be aware of requirements for a transition from the ad hoc level to the project level and the long-term commitment level. We can summarize the ideal configuration of partnership, with all parameters met, by the "TUFH Formula":

$$(MxV + MxP) \bullet A_3$$

where

V represents the four values of the "health compass": quality, equity, relevance, cost-effectiveness. Mx indicates a maximum of these values.

P stands for the five partners: policy makers, health managers, health professionals, academic institutions and communities. Mx indicates that all five partners are involved.

A stands for the quality of alliances; 3 stands for level 3, or the optimal level of partnership, exemplified by long-term commitment.

DISSEMINATION

The word "dissemination" conveys the notion of "spreading the seeds." The *raison d'être* of a project is to be reproduced so that lessons learnt benefit the entire health service delivery system and the people it intends to serve. Promoters of a TUFH project must acknowledge the support they receive by being accountable for both the quality of the "seeds," or the intrinsic value of the project, and the preparation of the "ground," or facilitating the growth and fruition of the project on a wider scale.

Advocacy

To efficiently market the concept of the "TUFH" project, it is important to reaffirm from the outset the basic values for which it stands: quality, equity, relevance and cost-effectiveness in health, as well as the key perception that the current fragmented health care delivery system cannot express these values satisfactorily.

The TUFH project is then presented as one approach among others. Support for the project should be gained if its main features are clearly outlined and its relevance to the local context is demonstrated, from the standpoint of policy orientation as well as field implementation.

Figure 24 below recapitulates the project features.

Because of the project's complexity, lukewarm support may have to be overcome at its inception and its promoters may need to exert their powers of persuasion to cope with doubters who demand constant reassurance to adhere to the project principles. However, the highest authorities in health service organizations, professional associations and academic institutions should be sympathetic and supportive, if the project is presented in a non-ideological and non-threatening manner and with a clear vision of its flexibility for adaptation and its long-term benefits.

Expansion

Once the project gets started, the momentum should be maintained. In a given project, very often, one partner may take the lead and others may lag behind, at least temporarily. Attention should be paid to ensure that in the full course of the project, all partners do their share.

Lessons learnt from monitoring project implementation should be incorporated. Tools should be constantly improved, such as the appropriate use of epidemiology by partners across the board to ensure a reference population perspective; alternative organizational patterns for optimal integration of medicine and public health, at different levels of the health system; use of health information through informatics and telecommunications technologies, for better decision making and as a catalyst for creating unity.

1. AIM:	Service based on people's needs
2. VALUES:	Quality, equity, relevance, cost-effectivenes
3. OBJECTIVE:	To reduce fragmentation in health systems and create unity
4. STARTING POINT:	Integration of medicine and public health
5. TECHNICAL NEEDS (3):	Reference population, organizational model, health information management
6. PARTNERSHIP (5):	Policy makers, health managers, health professionals, academic institutions, communities

Figure 24. TUFH in a nutshel

Valuable experiences should be widely disseminated. Networking among those with shared experiences should be encouraged both nationally and internationally. When some degree of visibility and credibility is gained, the sponsorship of government agencies should be actively sought, in the expectation that principles and methods imbedded in the TUFH project could be used to influence health policies and shape the health service delivery system nationwide.

EFFECTS

Project promoters and contributors must bear in mind that the ultimate aim is to improve quality, equity, relevance and cost-effectiveness in health services for the reference population. The definitions proposed for these four values are as follows.

Quality:	Optimal compliance with user satisfaction and professional standards.
Equity:	The state in which opportunities for health gains are available to everyone.

Relevance:	The degree to which the most important and locally relevant problems are tackled first.
Cost-effectiveness:	The greatest impact on health with the most appropriate use of available resources.

It is difficult to relate interventions to outcomes in the health field, particularly when numerous confounding factors and multiple partners exist. This should not discourage TUFH project promoters from searching for evidence of direct or indirect contribution to expressing these values, however. Although appropriate methodologies for evaluative research should be developed, everyone involved should be alert for signs of impact.

The project should collect baseline data regarding the four values as applied to the reference population, to regularly assess trends through appropriate means and mechanisms. Each stakeholder/partner can take specific measures to move towards expressing any of the four values. In the "social accountability" grid proposed to academic institutions, for instance, a taxonomy of interventions with graduated influence on these values is suggested. A similar grid could be adopted for use by other partners.

In any case, both separate and convergent inputs from partners should be documented. Results can range from immediate and fragile to long lasting. On one hand, for instance, volunteers can start a clinic to care for common ailments in an underserved group. On the other hand, the national legislature may pass a law to allocate a sizeable part of the health budget to local initiatives that meet the criteria of the TUFH project.

Conclusion

The value of the "Towards Unity for Health" project would be amply demonstrated if it contributed only towards changing the mindset of each of the different partners/stakeholders to accept shared responsibility and some accountability for the performance of the health system and for the health and well-being of their fellow citizens.References

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Toward Unity for Health

The Phuket Charter

The participants in the first International Conference **Toward Unity for Health** meeting in Phuket, Thailand, on this date of August 13, 1999, hereby present this CHARTER to serve as a foundation for the development of partnerships to assure the health of all people worldwide.

TOWARD UNITY FOR HEALTH

On December 10, 1948, the General Assembly of the United Nations adopted the Universal Declaration of Human Rights. Within this declaration lies the fundamental notion that each person is equally entitled to benefit from those conditions and services that promote and protect human health and wellbeing (Article 25). Subsequent reinforcement for this important human right is found in both Resolution 1997/71of the United Nation's Commission on Human Rights and the World Health Organization's *"Health for All"* campaigns derived from Resolution WHA30.43 (1977) of the World Health Assembly. The notions of health-related human rights are also found in the codes of professional ethics and conduct for physicians, nurses and many other health professions worldwide.

While there has been broad recognition of these ethical foundations for professional providers of health services and a general global endorsement of health-related entitlements for all people, these important concepts have not yet been incorporated into a charter that recognizes that optimal human health cannot be achieved without the contributions of multiple parties and sectors working in partnership together across society. This recognition underpins the intent of *Toward Unity for Health* and this charter.

The Ethical Foundations of Unity for Health

Health services and healthful environments as human rights:
We believe that each person is entitled to the environments and services that foster good health and wellbeing. It is the ethical obligation of all of those whose work affects health to assure the development and maintenance of the societal, political, environmental and economic conditions necessary for human health and wellbeing.

The good of individuals and wellbeing of communities:
We believe that the good of individuals and wellbeing of communities are inextricably linked. As such, all of those whose work affects health must give careful consideration of the needs of each and their impact on one another. This requires that each individual, agency, company, institution and government be mindful of the importance of the community good – the good of the whole and that of each person – in all that they do.

The importance of health promotion, protection and disease and injury prevention as the foundations for achieving optimal health:
We believe that the health and wellbeing of individuals, families and communities are best achieved through the provision of services aimed the promotion and protection of these states and the early prevention of disease and injury. We believe that the development and support of all services and systems focusing on human health should be based on this notion.

Building the linkages and partnerships necessary for optimizing human health:
We believe that human health is, in large measure, the consequence of individuals, communities, groups, institutions and systems working successfully in partnership across professional, private, public and voluntary sectors. We believe that building these linkages and partnerships effectively benefits from a common foundation of shared purpose and beliefs.

Encouraging governmental action that promotes and protects health through fostering appropriate partnerships:
We believe that governments of all countries are responsible for assuring the health and wellbeing of their citizens and those who seek refuge within their borders. In order to fulfill this important responsibility, governments must act in ways that encourage the formation and strengthening of partnerships that are in the public's interest and act to assure the ongoing public benefit from these.

The continuing responsibility and accountability of all involved in health services for assuring the health and wellbeing of those they serve:
We believe that all of those whose work impacts health share the continuing responsibility and accountability for the health and wellbeing of the individuals and communities that they serve. We believe that this responsibility and accountability is best achieved in the framework of shared belief and systems of appropriate legal and professional accountability.

The primacy of human health over the individual gain of those providing services:
We believe that the fundamental measure of the success of health services and systems should be their impact on the health and wellbeing of people and the communities in which they live. We further believe that the economic and social models underpinning all health services and systems should be structured to assure the continuing primacy of human health above all other considerations.

Working draft: 8/99